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# DYING IS A LIVING PROCESS: A STUDY OF THE COST-EFFECTIVENESS OF INITIATING A HOSPICE AT MADIGAN ARMY MEDICAL CENTER WITH IMPLICATIONS FOR ARMY-WIDE UTILIZATION

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by

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This study examined the cost effectiveness of initiating an inpatient hospice program in an Army treatment facility, Madigan Army Medical Center. The data examined were derived retrospectively from established hospices. This study concluded that establishment of a hospice in a military facility would probably be cost effective. Due to the restrictions against hospices in the military facilities, the author proposes and alternative system. The proposed 'Continuing Care Unit' offers the advantages of the hospice while not using the facilities of the hospital. key words: military medicine; medical services; health care facilities;

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## ACKNOWLEDGEMENTS AND FOREWORD

This paper started out to be a measurement of facts, an analysis of the costs of hospice care compared to aggressive care in order to make some inferences relevant to military medical treatment facilities. It has become much more than a mere measurement. Rather, it has developed into a real project -- much different from first conception but also more meaningful and useful. From a comparison of values has evolved a specific, workable design which has been submitted to U.S. Army Health Services Command for funding.

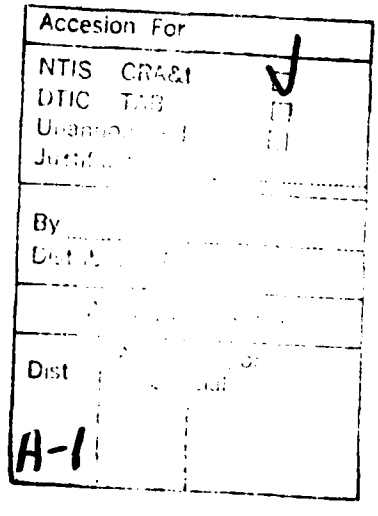
It is important to me to now say "thanks" to my Preceptor, Colonel Carshal A. Burris, Jr., without whom my paper as well as my residency year would have been a mere exercise. It is he who has by example shown me that to persevere, to right your mistakes, redesign, and keep going, is the only way to true success. For a year now he has suffered my verbosity, allowed me to ventilate my (frequent) frustrations, and corrected my grammar with a straight face which has at times, I'm sure, belied true mirth. All this he has done with patience and kindness which I'll never forget.

Brigadier General Guthrie L. Turner, Jr., the Commander of Madigan has given unfailing support to this project, urging me not to be discouraged when at times I have been. Thank you.

And last but never, never least, I express true gratitude to Ms. Betty Pugsley, who has provided emotional support throughout this year with always a smile and uncanny understanding. In addition, she

has typed --- and typed --- and typed, displaying not only technical expertise but the desire for a perfect product.

It is at this point that I must confess that I have learned abundantly this year, so much more than I had dreamed, and I am again most aware of all that I have yet to hear and understand.

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APPENDIX

# I. INTRODUCTION

## General Societal Implications

Precedence implies that the Armed Forces, as a segment of society merely mirrors those societal expressions of behavior concurrently displayed within the civilian community. Ergo, the problems and concerns that exist in the medical field today permeate military boundaries.

The foci of society as a whole emanate from an unstable economy.[1] The rate of inflation continues to increase, unemployment is at an all time high, and concomitantly, individual emphasis upon health care and hospitalization decreases.[2] The average citizen is looking for the greatest value for money expended and the philosophy of society has come full circle from the general medical doctor to the narrow specialist to the family practitioner.[3] Parallel to this has traveled the preoccupation of a society with heroics, death being an unacceptable termination of life, to the realization that life naturally ends in death.[4] To that end then, that life terminates in death, evolves the realization that death is a living process; that as a special and significant event of life a great deal of respect is due that stage, and careful preparatory consideration has been given to the best method of insuring a meaningful and humane ending to an individual's life experience.[5] This is both a philosophical as well as a realistic concept based upon a heavily increasing number of elderly afflicted now with chronically debilitating illnesses that modern

medicine has not as yet conquered and balanced with knowledge that the natural resources required to support such a growing segment of society decrease daily.

Therefore a multifaceted problem exists for the world, and the United States specifically, in the twentieth century. The philosophical and realistic avenues approaching death are following a parallel course, converging in the development of a humane focus for the dying process.

The vehicle utilized to accomplish the above is the Hospice. A hospice is a facility; it is a philosophy.[6] The goal of the program is integration and coordination of medical, social, and community services to support the patient and family that face a terminal illness.[7]

Does this problem exist in the Armed Forces as well as civilian life as intimated above? Yes. The same technological advances and changes in perceptions of medical care have occurred in the military. The acuity of the ill has increased throughout society due to an aging population, so that patients live longer but when ill, they are very ill.[8] Therefore, with much the same number of nurses as years ago, a greater number of patients who are very ill are being cared for, aggressively, and their care has been in the military as well as civilian life, perceived to be inadequate in relieving the mental and physical stress of the terminal patient and his family.[9]

However, the military has not attempted to compensate for the above inadequacies as has the civilian counterpart. The civilian segment has experienced much difficulty in establishing such a program. Philosophy had to change from an emphasis upon curing to caring and the contemporary physician has found this to be difficult in the era of accomplishing the impossible, the respirator![10] Also added to this has been the reimbursement factor.[11] Change comes slowly and third party reimbursers have remained reticent in the quest to insure for hospice care.[12] Reasons for this have varied, but lack of historical precedence and lack of concrete cost-effectiveness data have headed the list.[13] Although there is a bill now before Congress which would add hospice reimbursement to the Medicare package,[14] frank compensation has been conspicuous by its absence. Although thought to be comparatively cheaper than acute hospital care,[15] without insurance coverage many have been denied care specific to the terminally ill. Within the military setting, the hospice has not been studied. A request for funding for such a unit originated from Fort Leonard Wood in October of 1981 but was denied on legal grounds.[16] The mission of the Army is to care for the active duty soldier. The active duty soldier is separated from the service in the event of a terminal or severly debilitating disease and would then utilize eligibility to the Veteran's Administration Hospitals, who <u>are</u> studying the advantages as well as disadvantages of such a concept.[17] However, that leaves dependents of active duty in addition

to the retired soldier and his dependents who are cared for in military institutions due to individual need and training for legitimate physician internships and residencies.[18] Concomitantly, therefore, the population in question does exist in the military setting just as it does in civilian life, and additionally, those retired at age 45 after 20 years of military service rarely have hospitalization insurance in that their care has been provided throughout their careers. That leaves an appreciable gap between retirement and Medicare, thus exacerbating the problem.[19] From data accumulated through Madigan Army Medical Center 1981 records, it is evident that as in civilian society, the Army is experiencing much the same problem of lack of appropriate care for this category of patient (see Appendix A).

## Statement of the Problem

Would the institution of an Inpatient Hospice Program be cost-effective in Army Treatment Facilities -- specifically, Madigan Army Medical Center?

## Objectives

1. Determine dollar costs as well as "uncalculable" costs of a sample of patients receiving inpatient hospice care at a civilian institution.

2. Determine the dollar costs as well as "uncalculable" costs of terminal patients receiving traditional care in an acute setting at Madigan Army Medical Center.

3. Compare the results of numbers 1 and 2, evaluating the costs of the present acute care and hospice care.

## Criteria

The hospice movement has defined its own criteria/standards for terminal care as delineated by the National Hospice Organization:

1. Appropriate therapy is the goal of hospice care.
2. Palliative care is the most appropriate form of care, when cure is no longer possible.
3. The goal of palliative care is the prevention of distress from chronic signs and symptoms.
4. Admission to a hospice program of care is dependent on patient and family needs and their expressed request for care.
5. Hospice care consists of a blending of professional and non-professional services.
6. Hospice care considers all aspects of the lives of patients and their families.
7. Hospice care is respectful of all patient and family belief systems, and will employ resources to meet the personal philosophic, moral, and religious needs of patients and their families.
8. Hospice care provides continuity of care.
9. A hospice care program considers the patient and the family together as the unit of care.

10. The patient's family is considered to be a central part of the hospice care team.
11. Hospice care programs seek to identify, coordinate, and supervise persons who can give care to patients who do not have a family member available to take on the responsibility of giving care.
12. Hospice care for the family continues into the bereavement period.
13. Hospice care is available 24 hours a day, seven days a week.
14. Hospice care is provided by an interdisciplinary team.
15. Hospice programs will have structured and informal means of providing support to staff.
16. Hospice programs will be in compliance with the Standards of the National Hospice Organization and the applicable laws and regulations governing the organization and delivery of care to patients and families.
17. The services of the hospice program are coordinated under a central administration.
18. The optimal control of distressful symptoms is an essential part of a hospice care program requiring medical, nursing, and other services of the interdisciplinary team.
19. The hospice care team will have: a) a medical director on staff, b) physicians on staff, and c) a working relationship with the patient's physician.

20. Based on patient's needs and preferences as determining factors on the setting and location for care, a hospice program provides inpatient care and care in the home setting.
21. Education, training, and evaluation of hospice services is an ongoing activity of a hospice care program.
22. Accurate and current records are kept on all patients.

## Assumptions

1. Madigan Army Medical Center, under the auspices of the present Commander and Executive Officer, will support a hospice if found to be cost-effective.

2. The Commander, Madigan Army Medical Center, will authorize the needed allocation of personnel if the project is cost-effective.

3. The number of dying patients will remain commensurate with the number stated in the Introduction, or it will increase slightly.

4. There will be physical space allocated for a hospice within the confines of the present facility.

5. Each patient included in the sample is aware of his/her impending death and does not expect cure from hospital staff, or medication or treatment.

## Limitations

1. The hospice cannot be studied within the Army system. Therefore civilian hospice care must be evaluated with the eventual conversion and comparison of figures.

2. This facility is a medical center with all the teaching and research responsibilities of such. The conclusions drawn from this study may not approximate those drawn from a medical activity.

3. The West Coast will be the geographical area of study due to cost changes indicative of geographical regions.

## Research Methodology

The following will be utilized to determine the cost-effectiveness of hospice care at Madigan Army Medical Center. The dollar calculable costs for care will be determined by utilizing a geographically similar civilian facility. A sample of ten terminal patients who are in the end stages of life and being supported by inpatient hospice care will be used. The diagnosis of patient must be cancer. There must be at least one devoted family member or significant other physically within the geographical area, and the patient must be, at the onset of the end stage, cognizantly coherent and able to communicate.

Measured will be the cost for each patient of the following:

a) Room

b) Physical Nursing Care

c) Social Work Time

d) Pastoral Care

e) Volunteer Time

f) Physician Time

g) Laboratory Tests, in Number and Cost

h) Meals

i) Medication

j) Clerical Time

k) Escort Time

The above information will be gathered by the author by retroactive chart audit from the civilian source hospice, be compared to civilian source aggressive treatment, and then by matching diagnosis, the same information will be elicited from Madigan charts of aggressive care. The results will be compared and conclusions drawn as stated in Objectives Section.

## Unforeseen Problems Relating to Study

The main tool for comparison to be utilized in this study was cost data derived from the inpatient hospice scheduled to open 1 February 1982, which was to be compared to data acquired at Madigan, matching disease of individuals. The unit, which was to be housed in Tacoma General Hospital, Tacoma, Washington, has not opened. Future date is now, after gradual but consistent monthly setbacks due to funding, 1 July 1982, which will be too late for this study.[20] There are no other inpatient facilities in the State of Washington, and due to even more recent time changes relative to Tacoma Hospice, the Kaiser Hospice in California could not be used. Therefore, a limited number of patients treated with the hospice philosophy while on Tacoma General's Oncology Unit may, depending upon time constraints of civilian hospice source, be compared with patients treated aggressively on the Oncology Unit of that facility. These will be compared, if applicable, to retroactive cases treated aggressively at Madigan.

If no disease match is available then inferences will be made, using cost-effectiveness studies from other West Coast civilian medical treatment facilities and recommendations for future study will be devised. Obviously, "uncalculable costs" were not derived due to lack of study group.

The review of these inferential West Coast cost studies will be presented in the Discussion of this paper, followed by what data was locally acquired if possible. The conclusion to the study will present specific recommendations for an alternate project devised by the author to achieve the benefits needed in terms of education and support to patient and family members of the military who may require assistance in termination of life.

Although twelve hospice philosophy patients were isolated, only two matches of diagnosis were found prior to typing. Inferences will now be made as delineated above.

## Local Factors Bearing on Study

During calendar year 1981, 247 deaths were recorded at Madigan Army Medical Center. One hundred thirty-six (136) of these deaths were due to a chronically debilitating disease (see Appendix A). Perusing this chart it is apparent that aggressive treatment of these individuals ranged in cost from $225.39 for one day to $54,094.98 for a person with Cancer of Tongue, in the hospital on an acute care unit for 108 days. Most of these patients died of cancer or complications thereof. There were, usually, several

admissions within the last six months of life. Also of note is how the costs were derived (see Appendix B, UCA Cost Schedule per Unit). Utilizing guidance from Department of the Army, costs were calculated in a manner as to support comparison Army-wide, as well as Armed Services-wide. Although in its infancy and subject to initial error, these figures were utilized to compare costs of care from unit to unit as far as ICUs are concerned, and service to service for all others. From this data it can be seen that much money is being expended in the care of the terminal patient on the acute ward.

It is, as intimated early in the Introduction to this study, notable that the acuity of the patient admitted to Madigan is rising as it is also in the civilian sector.[21] (See Appendix C.) Madigan cares for an average census of 328 inpatients, with approximately 155 inpatient registered nurses.[22] This is analogous to 20 minutes of professional nurse-patient interface per shift, per nurse. Since Madigan, on its Medical and Surgical Units, utilizes acuity based nursing coverage (See Appendix D - Acuity Based Nursing Units) the interface increases significantly in the Critical Care Units and decreases in the Minimal and Admission Units. However, nursing coverage remains a constant problem[23] and concomitantly, cost of care.

Of 14 civilian registered nurse separations last quarter, 40% gave as a major reason for quitting an inability to give prioritized care,

education of patient and family, and inability to take part in discharge planning.[24] A communications survey distributed throughout the facility elicited comments analogous to the above by 63% of RNs and LVNs combined.[25]

Within the above mentioned 328 patients monthly, a segment of such is quite obviously terminal. Social Services has attempted to place many in convalescent homes but due to age (no Medicare until 65) and lack of money and insurance, this has been problematic. (See Appendix E - Social Services Placement Data.) This segment, compares to a civilian population[26] and civilians have attempted to devise a better, specific way to care for the terminally ill, the Hospice.

Would it be in the best interests of the government and in the best interests of Armed Forces beneficiaries to initiate hospice care within medical treatment facilities? Since there are none in the Army to study, cost data from civilian facilities will next be presented.

## FOOTNOTES

[1]John K. Iglehart, "Reagan's Prescription for Health Industry: Cut Federal Costs," Hospital Progress 61 (January 1981): 13.

[2]Victor R. Fuchs, "The Economics of Health In A Postindustrial Society," Commentary 99 (October 1979): 775.

[3]Thomas J. Stachnik, "Priorities for Psychology in Medical Education and Health Care Delivery," American Psychologist 35 (January 1980): 8.

[4]Andrew C. Twaddle and Richard M. Hessler, A Sociology of Health (St. Louis: The C. V. Mosbey Co., 1977), p. 156.

[5]J. M. Zimmerman, M.D., "Experience With a Hospice-Care Program for the Terminally Ill," Annals of Surgery (June 1979): 684.

[6]"Experts Probe Issues Around Hospice Care," Hospitals 54 (1 June 1980): 65.

[7]Ibid.

[8]Fuchs, p. 776.

[9]Norman T. Walter, M.D., Ph.D., Hospice Pilot Project Report, Kaiser-Permanente Medical Center, Hayward, California 1979, p. 58.

[10]Twaddle, p. 180.

[11]"Freestanding Hospices Uneconomical?" Medical World News (December 7, 1981): 35.

[12]Barbara J. Ward, "Hospice Home Care Program," Nursing Outlook (October 1978): 649.

[13]"Freestanding Hospices Uneconomical?"

[14]"Legislative Update," National Hospice Newsletter (November 1981): 5.

[15]Ward, p. 647.

[16]Telephonic Interview With Captain Larry Ellis, Administrative Resident, Fort Leonard Wood, Missouri, February 1982.

[17]"Hospice Revisited," UCLA Cancer Center Bulletin (May 1981): 9.

[18]Patient Administration Division Census Information, Madigan Army Medical Center, Tacoma, Washington, 1981.

[19]Interview With Major Willie Wooten, Social Work Service, Madigan Army Medical Center, Tacoma, Washington, 18 November 1981.

[20]Interview with Ms. Ann Katterhagen, Director, Tacoma Hospice, Tacoma, Washington, April 1, 1982.

[21]Interview With Colonel Beverly Glor, Chief, Department of Nursing, Madigan Army Medical Center, Tacoma, Washington, February 12, 1982.

[22]Ibid.

[23]Ibid.

[24]Colonel Richard J. Kaminsky, Madigan Army Medical Center, Compilation of Statistics Taken From Verbal Exit Interviews, April 1, 1982.

[25]Colonel Beverly Glor, Madigan Army Medical Center, Communications Survey, Disseminated from Communications Task Force, October 1981.

[26]"Evaluation of Hospice Care Still Needed," Hospitals (November 1980): 56.

## II. DISCUSSION

### University of California - San Francisco

With the exception of Tacoma Hospice, the inpatient hospice the author planned to study, the National Hospice Organization, McLean, Virginia has no record of another within the State of Washington.[1] Therefore, in keeping with geographical parameters, California was researched carefully.

Doctor Henry S. Perkins, M.D., of the Institute for Health Policy Studies, University of California - San Francisco, studied care for the terminally ill and compared data from two inpatient hospices within the San Francisco area and an acute care hospital nearby. This was accomplished by retrospective review of patients' charts.[2]

Certainly not conclusive but adding to the growing amount of information, his data only piqued the interest of the questioning practitioner. The average daily number of laboratory tests and the average daily laboratory charges were respectively: 2.07 tests and $39.17 for the hospital; .27 and $4.62 for one hospice, and .06 and $0.92 for the other. Vital signs were used as a measure of diagnostic tests for which there is no direct billing. The average number of vital signs ordered and charted were three for the hospital and zero for one hospice. Patients at the other hospice averaged one vital sign ordered.[3] The trend shows more orders for the hospital, therefore more cost.

Hospice of the Monterey Peninsula, Carmel Valley, California

This free standing hospice is private and the Board of Directors have been chosen from the prestigious Carmel, California area. A telephone interview with the Medical Director revealed that terminal care can be provided more cheaply at Hospice of Monterey than at the acute care facilities in the area.[4]

As of January 1982, the room rates for Hospice were $195.00 for a single room, $180.00 for a double room, an average of $190.00 per day per patient. This does not include general administration and assumes 100% occupancy. The Community Hospital charges $233.00 for a regular medical-surgical bed (no medications, no tests, no physician cost included) and $276.00 for an oncology bed. The Hospice bed is therefore 32% cheaper than acute care.[5] Note Cost Study for Inpatient Facility, which is Appendix F. Then peruse Appendix G, Proposed Program and Budget Report for the Fiscal Year July 1, 1981 through June 30, 1982. It is interesting to note that there is concern with and an ongoing effort to decrease costs, concomitantly expanding goals for service.

Veteran's Administration
Wadsworth Medical Center, Los Angeles, California

This Hospice is of great significance to those concerned with the military. The first of its kind, it has been in existance since February 15, 1978.[6] Presently it is undergoing extensive research by the UCLA Health Services Research Center. Six concepts are being

reviewed. Among these are efficacy of symptom control, number of diagnostic tests ordered, differences in the psycho-social health in the Hospice, and the VA Control Group, effectiveness of hospice in the goal to keep people home longer or to allow a home death rather than a hospital termination, evaluation of stress of bereavement, and costs versus benefits.[7]

The results of this study will be published in the summer of 1982. The ramifications will be far reaching in that institution of such a concept within the VA system might ease the burden of the medical treatment facilities sponsored by and for the active duty, albeit the dependents remain problematic and geography must not be overlooked.

Kaiser Permanente Inpatient Hospice, Norwalk, California

In consonance with the HMO goal of providing comprehensive care to its enrolees, cost is very important to the institution for any service deemed necessary to provide. It was with the above mentioned in mind that the Norwalk, California Kaiser Permanente HMO in 1979 began the cost study delineated below. Note that a factor was added to show a Medicare comparison in the original study. The author denied its necessity as related to any future military comparisons and therefore omitted this component where possible.

Kaiser Permanente opened a 15 bed hospice inpatient unit January 15, 1979.[8] With an average census of eight, the following study was conducted.

The study objectives for the feasibility study were as follows:

1. To determine the costs of providing care under hospice and non-hospice settings for terminal cancer patients in the last month of life.

2. To explain differences in costs in providing terminal care under the hospice and non-hospice settings in the last month of life.[9]

The major findings of the study were:

1. The average cost per patient for non-hospice care during the last month of life was $3,562.00, which was 22% more than the cost of hospice care, $2,929.00.

2. For both hospice and non-hospice care, over three-quarters of the per patient costs were associated with inpatient per diem costs. (See Appendix H for explanation of "per diem costs.")

3. Additional services that contributed to hospice costs included home care visits and ambulance trips. Other services that contributed to non-hospice costs included ancillary inpatient services and emergency room use.

4. The average number of days utilized during the last month of life was slightly higher in the non-hospice setting (11.44 days) than in the hospice setting (10.47 days). The small difference suggests that hospice inpatient days were almost a substitute for non-hospice inpatient days.

5. Nursing care differed in content between hospice and non-hospice inpatient settings. Specifically, hospice inpatient

nurses spent substantially more time than oncology nurses on teaching patients and families and supporting their emotional needs and in staff meetings.[10]

A short description of this indepth study is presented below. It is represented here to depict a thorough and specific, therefore creditable approach to the hospice cost issue.

Overview of Study Design.

The approach utilized involved comparison of the costs of providing care to two groups of patients. The first, the hospice group, was comprised of those individuals receiving hospice care. The second, the non-hospice group, was comprised of patients who were not receiving but who were prognostically appropriate for hospice care. The non-hospice group received care from the usual Kaiser-Permanente services prior to initiation of hospice services. Data was extracted for the last 28 days of life, using retroactive chart audit by staff on the research unit. The Benefit/Cost Department provided estimated costs for these services, and the Management Engineering Unit provided content of care data. Per patient costs were derived and the cost and content of the two types of terminal care were compared.[11]

Comparison Time Period.

Since the appropriate time of referral to hospice is three to six months, three months' costs would have been ideal. However, at the time of death many hospice patients had been under hospice care for less than the ideal time. Rather than biasing the sample by

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selecting only those patients with hospice lengths of stay of longer than three months, the study comparison time period was reduced to one month, or 28 days, thus obtaining a more representative sample.[12]

Weighing the Sample.

For both hospice and non-hospice data, a random sampling approach was chosen, stratified on the basis of primary cancer site. However, due to attrition that varied by cancer site the final samples did not have comparable distributions of this variable. Since it was deemed that the primary cancer site was significantly related to services used, the two samples were standardized. Using a weighting technique, the samples were adjusted to approximate the 1980 distribution of cancer deaths in the United States.[13]

Sample Group Selection - Hospice.

The hospice sample was comprised of patients who died while in the inpatient hospice during calendar year 1979. Of 239 deaths, a 100 patient sample was chosen. Of the 100, only those with lengths of stay of 28 days or longer were included for the final comparison. After the above weighting procedure was utilized, a sample size of 48 resulted.[14]

Sample Group Selection - Non-Hospice.

The non-hospice sample was selected from all Los Angeles medical center patients who expired during 1978 and who met the criteria of "prognastically appropriate." This relates to the list below:

a) Metastatic cancer to the lungs, liver, and/or brain.

b) Breast cancer with multiple bone metastasis.

c) Carcinomatosis or widespread abdominal metastasis.

d) Non-resectable cancer of the pancreas, esophagus or stomach.

e) Malignant plural effusion from cancer of the breast, ovary or lung.

f) Lung cancer with superior vena cava syndrome.[15]

The data source of the non-hospice group was the Los Angeles Medical Center Cancer Registry. Deaths in 1978 were used because confusion with the impact of an ongoing inpatient hospice was to be minimized. The sample was weighted according to primary cancer site with a resulting sample size of 50.[16]

Development of Costs.

(Objective 1) In determining overall costs for care of the terminally ill, a set of variables delineating services patients were most likely to elicit was developed. Unit costs were obtained from existing data where applicable; others were developed for the study. (See Appendix I, Kaiser Permanente-Norwalk, Average Utilization of Service Rates.) This is interesting to the author in that the Army Uniform Chart of Accounts has also computed these same costs for future reference and perhaps future comparison.

Explanation of Cost Differences.

(Objective 2) To accomplish this explanation, the proportion of total costs attributable to varied services was explored. In

addition, comparisons were made between the content of nursing care and average number of patient days for the hospice and non-hospice group.

Appendix J, Kaiser Permanente-Norwalk Percentage of Costs Attributable to Each Service, shows that for both hospice and non-hospice, inpatient per diem costs were responsible for approximately 80% of the total costs. For hospices, 42% of total costs were due to inpatient nursing while other inpatient per diem costs accounted for 35% (see Appendix H, Kaiser Permanente-Norwalk Development of Costs for Services, for specific services included in this category). In the non-hospice area, 30% of costs were associated with medical-surgical inpatient nursing. Although less than hospice, it was substantial. Proportion of non-hospice medical-surgical other inpatient per diem costs was similar to that of the hospice - i.e., 31% of non-hospice total costs.[17]

A combination of inpatient non-hospice laboratory and radiology costs accounted for approximately 10% of total costs. Hospice costs were negligible.[18]

Hospice care does not seem to greatly decrease patient utilization if 10.47 days length of stay, compared to non-hospice stay of 11.44 days, is accurate.[19]

Further adding to the cost picture was an examination of content of nursing care, using management engineering data collected from the hospice and the oncology unit, Los Angeles Medical Center. One difference was the variety of care provided by nursing staff. The

oncology nurses performed a variety of tasks, while the hospice nurses were found to perform a limited number of tasks frequently. These limited tasks were teaching patients and families and supporting their emotional needs, dangling and ambulation, assistance with elimination, and assistance in eating.[20]

Of interest was the distinction between the hospice and non-hospice proportion of time spent in emotional support and teaching. Due to orientation of care it was expected that the time spent in the above in the hospice would indeed be greater. The data was indicative of this. The oncology nurse spent 3% of her time performing support and teaching tasks; the hospice nurse, 30%.[21]

Recommendation.

The recommendation to Kaiser Board of Directors was to include hospice services as a benefit for HMO enrolees.

Implications to the Military.

The HMO service schedules approximate the military in that once a set fee is paid by the enrollee, care is given on a need basis with no charge per visit.[23] This approximates the military schedule of service and of course, it has been found statistically that the patient utilizing either of the above accumulates more visits than the patient enjoying benefits of a deductible fee or private payment.[24] In this area, the HMO, the military and Veteran's Administration are quite comparable and thus credibility is added to any comparisons made.

## Kaiser-Permanente Hospice Pilot
## Kaiser-Permanente Medical Center, Hayward, California

Also evaluated, but evaluated independently and in isolation from the prior mentioned Norwalk facility, was the Hayward Pilot Hospice, another arm of the Kaiser-Permanente California services. Due to the above mentioned isolation and the desperate need for well accomplished, creditable cost studies, the decision was made to add it to the compilation of facts.

The facility opened in November of 1977.[25] A retroactive comparative study of costs was accomplished by comparing data compiled for 45 patients receiving normal, aggressive treatment prior to the opening of the facility, with a segment of 62 patients who died during the six month period, April through December 1978, following the opening of the Hospice Program.[26] Of the sixty-two who expired after inception of Hospice, 52 selected hospice care; ten did not. The choice was theirs.[27]

The costs examined were those of the last 60 days of life. This 60 day period included the 35-day mean stay added to a period of clinical and laboratory tests associated with the physician's decision for which patient eligibility for the program supposedly occurred.[28] The costs incurred in this testing period were added to the 35-day stay to avoid discontinuity associated with the conclusion of any aggressive treatment. Even though a large number of the costs shown to be after inception of the hospice were generated before the patient was referred for care, the costs were added to insure comparability and because it

was the belief of the group studying the concept that the impact of hospice upon the style of physician practice continues after the physician leaves the inpatient unit.[29]

An attempt was made to include all ongoing hospice costs. However, there is a desire to recalculate and restudy costs at least one year after, thereby capturing more true savings generated by new physician practice patterns.[30]

Extracted retrospectively from patient charts were amounts of direct cost, types of treatment, cost-related factors such as home health visits or quantity of bed days. (Again, Medicare reimbursement was omitted by the author for above mentioned reasons.) Pharmaceutical costs were omitted by Kaiser due to difficulty in extracting accurate information.[31]

The charges from the years 1978 and 1979 published in the Kaiser fee schedule were utilized to determine the cost for each visit, test or procedure for both the hospice and non-hospice group.[32]

The analysis of data, although utilizing a comparable six month period of time, did include 62 hospice patients, while 45 comprised the non-hospice segment. This was not statistically significant at the 5% level.[33]

The main types of cancer approximated the national average, as did the percentages of each.[34]

Explanation of Cost Differences.

A direct comparison of costs during the last 60 days of life showed a mean reduction in per patient charges of $813.00 for the hospice group.[35]

The services showing the greatest reduction were laboratory ($835.00), radiology ($24.00), nuclear medicine ($29.00), and operating room ($134.00). See Appendix K, Comparative Cost Data, Hospice, Non-Hospice Patients.[36]

The major differences seen in the operating room, radiology and laboratory were the results of extensive treatment of one individual who was taken from the non-hospice group. This individual was considered important because that care exemplified the traditional, aggressive care most often experienced before hospice. As a test of the significance of this data upon the compilation of data, the results were adjusted by deducting the cost of the most expensive patient in each group. The result displayed a still noticeable reduction in the above ancillary services. However, as can be discerned in Appendix L, the increase in nursing care and Hospice Team (interdisciplinary team comprised of chaplains, social workers, etc.) rendered the cost equal for both groups.[37]

In an attempt to further test the validity of the conclusions, both groups were weighted according to age and primary site. A cost saving for hospice was still realized.[38]

Further study showed that on the average the hospice group spent one day less in the hospital during the last 60 days of life; three days less in the last six months.[39]

The major cost savings was realized in physician direct care and ancillary costs, while costs of nursing care actually increased.

It was felt that the raw data could not be considered conclusive due to small sample size and approximate nature of the analysis. The sensitivity analysis indicated, however, that there has been no appreciable cost increases due to hospice care at the Hayward facility.[40]

## Author's Conclusions From Study Comparisons

The author would like to note the following:

1. Each study, while emphasizing direct costs, differed in variables.

2. Although inferences can be made from the compilated information, nothing definitive has been proven.

3. Further retesting of those specific programs evaluated within this paper would undoubtedly add significant homogeneous comparative data as well as further program to program comparison of costs.

4. Hospice care, as delineated in the Discussion of this paper, is not a more expensive mode of treatment for the terminally ill.

5. There is definite inference that ancillary costs decreased in three studies, while in two studies a noted result was an increase in nursing time.

6. The raw figures depicting cost per patient in each study were lower for the hospice group.

## FOOTNOTES

[1]Telephonic Interview with Ms. Barbara Featon, National Hospice Organization, McLean, Virginia, February 18, 1982.

[2]Henry D. Perliens, M.D., "The Ethics of Terminal Care, Hospital Forum 6 (Nov/Dec 1981): 11.

[3]Ibid.

[4]Telephonic Interview with Hospice Director, Hospice of Monterey Peninsula, Carmel Valley, California, March 8, 1982.

[5]Report of Committee on Fiscal Management for Board of Director's Meeting, January 18, 1982.

[6]"Hospice Revisited," UCLA Cancer Center Bulletin, p. 6.

[7]Ibid., p. 8.

[8]Kaiser Permanente Hospice Program, Norwalk, Cost Comparison Study of Hospice and Non-Hospice Terminal Care, December 1979, p. 1.

[9]Ibid., p. 11.

[10]Ibid., p. 12.

[11]Ibid., p. 15.

[12]Ibid., P. 12.

[13]Ibid., p. 11.

[14]Ibid., p. 14

[15]Ibid., p. 5.

[16]Ibid., p. 16.

[17]Ibid., p. 16.

[18]Ibid., p. 16.

[19]Ibid., p. 17.

[20]Ibid., p. 18.

[21]Ibid., p. 15.

[22]Ibid., p. 10.

[23]Ibid., p. 16.

[24]James A. Reynolds, "Why Catastrophic Health Insurance is Going Nowhere," Medical Economics (November 1979): 30.

[25]Norman T. Walker, M.D., Ph.D., Hospice Pilot Project Report, Kaiser Permanente Medical Center, Hayward, California, 1979, p. 1.

[26]Ibid., p. 146.

[27]Ibid., p. 146.

[28]Ibid., p. 147.

[29]Ibid., p. 147.

[30]Ibid., p. 149.

[31]Ibid., p. 148.

[32]Ibid., p. 148.

[33]Ibid., p. 148.

[34]Ibid., p. 149.

[35]Ibid., p. 148.

[36]Ibid., p. 148.

[37]Ibid., p. 149.

[38]Ibid., p. 150.

[39]Ibid., p. 150.

[40]Ibid., p. 150.

## III. CONCLUSION

### Cost-Effectiveness

The cost-effectiveness of the hospice has not been proven. It is obvious by the data accumulated, however, that the potential for a break-even cost (aggressive care versus hospice) or a lower cost for the hospice is great. Enough data has been generated to suggest that an Armed Forces' test would be feasible.

### Significance to the Military

As a mode of treatment for the terminally ill patient the hospice philosophy is indeed meritorious. More than 800 such programs exist in the United States in 1982.[1]

As noted earlier, acuity of patients rises with each succeeding year, the number of nurses available in the job market decreases.[2] The complexity of patient care increases, as evidenced by technological progress.[3] There is also a drifting away from heroics to acceptance of the truly inevitable, and a desire to provide a dignified, humane death as a stage of life.

The United States Army does not provide "custodial"[4] care by regulation. The focus of Armed Forces treatment is the active duty soldier, dependents, and then retired, as space is available.[5] However, the physician internship and residency programs which are so very much a positive force for Armed Service recruitment require a varied clientele as well as a specified number of learning experiences

per specialty. Therefore it is evident that active duty, dependent and retired are cared for in varied amounts in military medical treatment facilities.

As a corollary to the above, recruitment literature for the basic soldier extolls his benefits -- 30 days paid vacation, medical and dental care provided. No one stands at the recruitment station to specify that he may not receive care after retirement. Where is it made obvious to the soldier that if he retires at age 42-45 after twenty years of service, he may essentially be uncovered medically until the age of Medicare, for some a twenty year span?

It is the opinion of the author that until a "later-in-life" insurance co-payment policy is instituted for the soldier, or until the probable gap in medical coverage briefly delineated above is made abundantly clear upon recruitment, the Armed Services' medical treatment facilities should provide care, in both quality and array of services, analagous to the civilian sector.

The volunteer Army must market to those available for recruitment in civilian life, yet in this "catch twenty-two" situation civilians somewhat deem what types of services will be presented due to budgetary restraints mandated by Congress. Congress reacts to fact and societal desires.

A never ending, vicious circle certainly. However, how the allocated monies are to be utilized is somewhat flexible. This is

deemed by the author to be a strength of the system and allows for prioritization as well as the possibility of creativity. However, as is completely normal, change comes very slowly and the larger the system being challenged, the greater the time variance in effecting such.[6]

In October 1981, Fort Leonard Wood, Missouri formally requested to be allowed to provide hospice services to its catchment area. The idea was formally rejected. Legalities, i.e., question of legally relinquishing liability for death,[7] were given as reason. Therefore, the author has attempted to devise a program that could benefit both the chronically debilitated as well as the dying patient, considering the practical problems of decreased patient-nurse interface in the hospital, the increasing acuity explained early in this paper, the trend toward dying at home,[8] the need for patient and family teaching that Madigan Army Medical Center surveys have shown to be lacking,[9] and employing an emphasis upon cost-effectiveness of government funds. The "Continuing Care Unit" explained in the following pages is that attempt, and was first introduced to Health Services Command during the week of April 12-16, 1982, by the author. Favorable support was encountered; both funding for staff (7 RNs, 6 91Cs, and 2 ward clerks) and a temporary change in mission were requested. A re-submittal of data will be accomplished by the end of May to accompany the Command Operating Budget (COB) to San Antonio. An October 1982 date has been requested for a one year test of cost efficacy of such a unit. This 12-month period will include two

weeks initial orientation of staff to the unit and a two week period at the end to tabulate all the figures in preparation for permanent funding or cessation of the study unit.

## Alternate Approach -- "Continuing Care Unit"

### Philosophy

The philosophy of the unit surrounds the focus of emotional support, coping skills, and physical skills as necessary to enable a patient to accept his prognosis with a positive accepting attitude, formulate goals and work toward those goals.

This shall be accomplished with the assistance of an interdisciplinary team comprised of physicians, nurses, community health nurses, social workers, clergymen, pharmacists, dietitians, psychologists, occupational and physical therapy as needed. The family and the patient are treated as one unit of care, with assessment of strengths and weaknesses immediately followed by initiation of a teaching plan, composed of interdisciplinary intervention aimed at enabling the patient to leave the hospital as soon as possible and thus armed with physical "know how," coping skills and recognition of professional support, remain at home where he wishes to be, not in the hospital. See Appendix M, Integration of The Continuing Care Unit Within the Hospital. This unit will not be utilized for aggressive medical treatment in keeping with the above focus.

Criteria for Admission

The criteria for admission to the unit will be somewhat flexible. Patients will be comprised of (1) those with newly diagnosed, chronically debilitating diseases who require an interdisciplinary approach for support and knowledge, or (2) someone who has already accepted the prognosis indicative of his disease, and who wishes to learn as much about his care as possible so that he may be able to function at home. The unit may be utilized more than once upon the discretion of the medical and nursing coordinator in conjunction with the patient's primary physician.

Atmosphere and Physical Layout

The unit will utilize private rooms so that family members or significant others may stay if so desired. The decor will be comfortable, with plants and cheerful accouterments. The patient will be allowed to bring from home what makes him comfortable, i.e., pictures, bedspread, etc.

The atmosphere will be relaxed, unhurried, with focus directed toward assisting the patient in coming to grips with an ongoing problem. There will be no stringent rules; open visiting hours will be employed, especially since some family members will work and teaching must be accomplished on the unit when the significant other can be there. Dietary will furnish meals if so desired, but a kitchen will be made available so that a patient may enjoy his

own or his family's cooking, or in the case of a needed special diet, the patient and family member may practice with assistance. A lounge with television will be provided.

An office for staff, room for counselling, a room for staff conference and maintenance of records, and phones will be available. See Appendix N, Schematic Diagram, Proposed "Continuing Care Unit."

Services Rendered

The services a patient could hope to receive on this unit would be significantly different from that of an acute care unit where all care is now received. See Appendix O, Proactive Schedule X.

Upon admission, an Activities and Limitations History would be instituted. The information on this document would become the basis of unit interdisciplinary intervention and would include diagnosis, prognosis, patient and family goals, and potential stumbling blocks in their accomplishment. This information, in addition to daily activities found in a nursing history, would be gathered through interview upon admission to the unit. Then the nurse counsellor would discuss the joint goals of the patient and unit, and a plan of steps to reach that goal would be formulated in collaboration with the medical director and primary physician. Appointments would then be established with members of the disciplines needed to effect care. Length of stay on the unit would be directly in proportion to established need, individually calculated. Team members would record professionally appropriate information after each appointment and

discuss the plan of care with the nurse counsellor responsible at the time of appointment. Weekly interdisciplinary staff meetings will be firmly scheduled and other team conferences may be scheduled as needed. The unit will strive for a cooperative as well as collaborative relationship with the patient and family. Upon agreement of the applicable members of the team, the patient will be discharged home after a summarization of progress and discussion with the family and patient of potential problems which may occur. (Interface with Community Health and Logistics Division will be discussed below.) A special telephone number will be made available to all patients and their families upon discharge. This will enable utilization of a 24-hour consultation service which is an integral part of the program. Upon utilizing the service, the patient will be questioned and counselled by a registered nurse who will be cognizant of his/ her case history from an especially designed file located by the special phone, which will contain a copy of the Activities and Limitations History, his Discharge Summary which will be comprised of his problems and devised solutions to those problems, potential stumbling blocks to success isolated upon discharge, and comments. Using this information the nurse will talk with the patient or family member, ascertain if the problem is of a supportive nature, if a physical problem has arisen that needs explanation, or if the problem needs medical intervention. Appropriate steps will be taken to advise the patient. The consultation will be recorded in two places, the

patient's file folder and the record of Medical Care Composite Unit (MCCU) credits. A brief synopsis will be reported verbally in nursing report and a follow-up evaluative phone call will be planned within 24 hours unless the intervention of Community Health is necessitated.

Community Health Interface

Community Health will play an integral part as far as continuity and continued professional staff communication is concerned. Not only will this department attend all weekly staff meetings, and take an active part in discharge planning of the patient, but will be available to accomplish an at-home physical assessment of a budding problem initiated by the consultation service and communicate back to the Care Unit to discuss further intervention. (This intervention will be included in the patient's Activities File by the Community Health nurse practitioner.)

Physician Interface

The medical director will play an integral role in admissions and discharges to the unit, and act as arbitrator as problems arise. The primary referring physician will be invited to attend the weekly staff meeting to provide input concerning patients in the program or those he projects may enter the program. This continued communication will be needed as feedback as to progress the unit has made with a patient in terms of ongoing problems of both a medical and support nature.

Clinical Coordinator Interface

The Clinical Coordinator position at Madigan is one of positive staff and patient intervention. There are five such positions; Maternal and Child Health, Surgical, Medical, Critical Care, and Mental Health. These nurses act as teacher and support for the staff and some patients in their respective acute care sections. They enable the head nurse to be an administrator. These practitioners will be invited to the weekly staff meetings to receive an update on patients who were referred from their sections and to impart information on patients who, because of the need for special concentrated attention, may be referred. Their individual teaching and support strengths will also be tapped by the unit for individualized patient need.

Logistics Interface

No hospital ever functions effectively without sustained excellent logistics support. Keeping the purpose of the Continuing Care Unit in mind -- to support the patient in such a substantial manner that he may enjoy life at home for long periods of time -- Logistics interface will be very important. Close communication will be fostered with this department and a representative will be invited to attend weekly staff meetings. Departmental input will be utilized during initial orientation of staff to the Continuing Care Unit to insure

that correct procedures are instituted in ordering the apparatus a patient will need to accompany him home, and that it will, in fact, accompany him home.

Cost Implications

The question here is, "Can Madigan give better care more cheaply?" In order to ascertain the facts, a one year study has been proposed. However, there are several perspectives from which to approach the situation.

First, the eight bed proposed unit would make available eight medical or surgical acute beds that are now being utilized with the chronically debilitated patient. These beds could be then diverted for use by acute patients. The Medical beds within the facility run between 90 - 93% filled, while Surgery's statistics are 78 - 97%.[10] The spread of each is due to Madigan's cantonment facility and thus a bay ward situation, which is of course, driven by gender, thereby potentiating beds unoccupied while a backlog ensues. An average of 7.25 Medical and Surgical Nonavailability Slips are generated monthly.[12] If only 3 - 4 of these are directed back into Madigan, a savings of $130 - 150,000 could be saved from either CHAMPUS or supplemental care. This was calculated from Tacoma General Hospital 1981 1st quarter funding figures that state that the average cost per day for care in the hospital is $500.00 per day. If a surgical procedure is necessary, the physician's fee and anesthesia are not included.

There is also the hypothesis that with a specialized focus of care that the Continuing Care patient will remain out of the hospital for longer periods of time and that with continued support capability his medical admissions to the hospital will be of decreased length. (Peruse Appendix A once again, placing special emphasis on the number of admissions during the last six months of life and where those admissions occurred.)

Therefore, it is the task of the medical treatment facility to capture as much cost data as possible in an organized fashion during the test year.

Evaluative Cost Techniques

A Uniformed Chart of Accounts (UCA) will be instituted (see Appendix B). This information will be a compilation of information which will capture overhead, nurses' time, social work by visit and staff time, supplies, and physician time, thus giving the Center the ability to compare the cost of the "Continuing Care Unit" against other inhouse units.

A careful record of all telephone consultations will be kept since a telephone call is equal to a clinic visit for funding, i.e., equal to 1/3 of an actual admission.

For all individuals admitted to the Continuing Care Unit during the test, a tabulation of all admissions, lengths of stay, diagnoses, number of tests, etc., will be accomplished. See Appendix P, Continuing Care Test Data. Retrospectively, matched by diagnosis, the sample

taken from the year 1981 Madigan Admissions, will be the same number of patients admitted to acute wards. The same information will be elicited from the charts and a comparison will be made, utilizing the number of applicable tests, etc.

## Evaluative Techniques -- Perceptions of Program

Costs may be a deciding factor in continuation of a program but there is a need to know the perceptions of that program in terms of usefulness. See Appendix Q, Continuing Care Program Survey (Nurses, Physicians), and Appendix R, Continuing Care Unit Survey (Administrators, Supervisors). This information will also be tabulated and perused at the end of the study, as will patient's perceptions. (See Appendix S, Continuing Care Survey - Patients.)

## Concluding Remarks

The concept of the hospice is viable in our society; the hospice concept is currently prohibited in Armed Forces treatment facilities. However, there are ways to reap the same benefits with utilization of a different approach, the Continuing Care Unit. This unit, with its focus on the chronically debilitated, by providing education and support, sustains the patient at home for as long as possible. This concept permits the patient to live out the remaining time in a setting of his choosing and permits the medical treatment facility to use its acute medical facilities more effectively. This should be a major concern to us all as our beneficiary population is an aging one, and a consideration the Armed Forces medical planners and Congress must face.

## FOOTNOTES

[1]Telephonic Interview with Ms. Barbara Fenton, National Hospice Organization, McLean, Virginia, February 18, 1982.

[2]"Report Cites Nursing Shortages in All Patient Care Settings," Hospital Week 18-11 (March 1982).

[3]Victor R. Fuchs, "The Economics of Health in a Postindustrial Society, Commentary 99 (October 1979): 778.

[4]Interview with Major Manning, HSC Staff Judge Advocate, 16 April 1982.

[5]Department of the Army, Department of the Army Regulation 40-3: Medical, Dental and Veterinary Care (Washington, D.C.), U. S. Government Printing Office, October 1977: 2-3; 1-2; 4-1.

[6]Warren Bennis, Kenneth Benne, and Robert Chin, The Planning of Change, 2nd ed. (New York: Holt, Rinehart and Winston, 1969): 495.

[7]Telephonic Interview with Captain Larry Ellis, Administrative Resident, Fort Leonard Wood, Missouri, February 1982.

[8]Ann Kirchner Katterhagen, "Hospitals and Hospice: Do They Belong Together." Texas Hospitals (March 1980): 21.

[9]Colonel Beverly Glor, Madigan Army Medical Center, Communications Survey, Disseminated from Communications Task Force, October 1981.

[10]Interview With Colonel Beverly Glor, Chief, Department of Nursing, Madigan Army Medical Center, Tacoma, Washington, February 12, 1982.

[11]Patient Administration Monthly Nonavailability Issuances, Madigan Army Medical Center, 1 Mar 1981 - 1 Mar 1982.

[12]Ibid.

# APPENDIX A

## DEATHS DUE TO CHRONIC DEBILITATING ILLNESS
## MADIGAN ARMY MEDICAL CENTER, 1981

APPENDIX A

*DEATHS DUE TO CHRONIC DEBILITATING ILLNESS
MADIGAN ARMY MEDICAL CENTER
1981

| PATIENT | DEBILITATING DISEASE CANCER | DEBILITATING DISEASE OTHER | *ADMISSIONS DURING LAST 6 MOS OF LIFE | **LAST ADMISSION | COST OF LAST ADMISSION |
|---|---|---|---|---|---|
| 1 | Renal | | 1st - 1 day | 1 day (ICU) | 865.56 |
| 2 | Lung | | 1st - 3 days | 1 day (ICU)<br>2 days (Med) | 1,090.95 |
| 3 | Pancreatic | | 1st - 19 days | 19 days (Med) | 4,282.41 |
| 4 | Lung | | 1st - 2 days | 2 days (Med) | 450.78 |
| 5 | Astroyctoma | | 1st - 7 days | 7 days (ICU) | 6,058.92 |
| 6 | Lung | | 1st - 9 days | 9 days (Med) | 2,028.51 |
| 7 | | Cirrhosis | 1st - 3 days | 3 days (Med) | 676.17 |
| 8 | Lung | | 1st - 13 days | 12 days (Med)<br>1 day (ICU) | 3,570.68 |
| 9 | | Heart | 1st - 5 days | 5 days (CCU) | 1,730.60 |
| 10 | | P-Vascular Disease | 1st - 22 days | 22 days (MED) | 4,958.59 |
| 11 | Abdomen | | 1st - 18 days | 18 days (Med) | 4,057.02 |
| 12 | | Aneurysm | 1st - 48 days | 2 days (CCU)<br>46 days (ICU | 40,508.00 |

* Of 247 deaths in 1981, 136 fell into this category.
** Last Admission - Last admission in number of days followed by assigned nursing unit.

| | | | | | |
|---|---|---|---|---|---|
| 13 | Ovary | | 1st - 14 days<br>2nd - 1 day | 14 days (Surg) | 3,837.26 |
| 14 | | Ulcer | 1st - 13 days<br>2nd - 11 days | 4 days (ICU)<br>9 days (Med) | 5,490.75 |
| 15 | Breast | | 1st - 5 days<br>2nd - 9 days | 5 days (Med) | 1,126.95 |
| 16 | Breast | | 1st - 4 days | 4 days (Med) | 901.56 |
| 17 | Ovary | | 1st - 61 days | 61 days (Surg) | 16,719.49 |
| 18 | Endometrical | | 1st - 11 days<br>2nd - 11 days<br>3rd - 2 days | 11 days (Gyn) | 3,199.35 |
| 19 | Ovary | | 1st - 72 days | 72 days (Gyn) | 20,941.20 |
| 20 | | Heart | 1st - 1 day<br>2nd - 69 days | 1 day (Med) | 225.39 |
| 21 | | Renal | 1st - 71 days | 43 days (Med)<br>21 days (ICU)<br>7 days (CCU) | 30,291.37 |
| 22 | Leukemia | | 1st - 21 days<br>2nd - 30 days | 20 days (Med)<br>1 day (CCU) | 4,853.92 |
| 23 | Lunk | | 1st - 27 days | 2 days (Surg)<br>25 days (ICU) | 22,187.18 |
| 24 | | Ulcerative Colitis | 1st - 1 day<br>2nd - 13 days | 1 day (Med)<br>13 days (Med) | 3,155.46 |

| | | | | | |
|---|---|---|---|---|---|
| 25 | Lung | | 1st - 1 day | 1 day (N-S) | 274.09 |
| 26 | | Cirrhosis | 1st - 42 days | 42 days (Med) | 9,466.38 |
| 27 | | Heart | 1st - 1 day<br>2nd - 8 days | 1 day (CCU) | 346.12 |
| 28 | Uterus | | 1st - 31 days<br>2nd - 7 days | 30 days (Med)<br>1 day (ICU) | 7,627.26 |
| 29 | Lung | | 1st - 21 days | 21 days (Med) | 4,733.19 |
| 30 | Leukemia | | 1st - 20 days<br>2nd - 13 days<br>3rd - 3 days<br>4th - 7 days<br>5th - 3 days<br>6th - 12 days | 20 days (Hem) | 6,695.00 |
| 31 | Colon | | 1st - 23 days<br>2nd - 71 days | 71 days (Med) | 16,002.69 |
| 32 | Eye | | 1st - 1 day<br>2nd - 15 days | 1 day (ONC) | 334.75 |
| 33 | | COPD | 1st - 8 days<br>2nd - 13 days | 7 days (Med)<br>1 day (ICU) | 2,443.29 |
| 34 | | P-Vascular | 1st - 97 days | 4 days (ICU)<br>93 days (P-Vas Sur) | 29,468.29 |
| 35 | | Cirrhosis | 1st - 28 days<br>2nd - 28 days | 27 days (Med)<br>1 day (ICU) | 6,951.09 |
| 36 | Leukemia | | 1st - 10 days | 8 days (Med)<br>2 days (ICU) | 3,534.24 |

| | | | | | |
|---|---|---|---|---|---|
| 37 | Neck | | 1st - 1 day | 1 day (ENT) | 274.09 |
| 38 | Lung | | 1st - 18 days | 18 days (Med) | 4,057.02 |
| 39 | Pancreas | | 1st - 2 days<br>2nd - 11 days<br>3rd - 20 days<br>4th - 19 days | 2 days (ONC) | 669.50 |
| 40 | Prostate | | 1st - 9 days<br>2nd - 60 days<br>3rd - 23 days | 5 days (ICU)<br>4 days (Surg) | 6,068.76 |
| 41 | Brain | | 1st - 2 days<br>2nd - 10 days<br>3rd - 3 days | 2 days (ONC) | 669.50 |
| 42 | Lung | | 1st - 9 days<br>2nd - 22 days | 9 days (ONC) | 3,012.75 |
| 43 | Colon | | 1st - 47 days<br>(Incomplete Data) | 6 days (Surg<br>7 days (ICU)<br>9 days (Surg) | 11,073.71 |
| 44 | Prostate | | 1st - 101 days | 101 days (Urol) | 30,093.96 |
| 45 | Gallbladder | | 1st - 18 days | 18 days (Med) | 4,057.02 |
| 46 | Colon | | 1st - 19 days | 19 days (Med) | 4,282.41 |
| 47 | Lung | | 1st - 3 days<br>2nd - 4 days<br>3rd - 5 days<br>4th - 3 days | 3 days (Med) | 676.17 |

| | | | | | |
|---|---|---|---|---|---|
| 48 | Leukemia | | 1st - 21 days<br>2nd - 11 days<br>3rd - 10 days | 21 days (Med) | 4,733.19 |
| 49 | Leukemia | | 1st - 11 days<br>2nd - 10 days<br>3rd - 21 days<br>4th - 1 day<br>5th - 5 days | 8 days (Med)<br>3 days (CCU) | 2,841.48 |
| 50 | Lung | | 1st - 4 days<br>2nd - 11 days | 4 days | 901.56 |
| 51 | | Cirrhosis | 1st - 1 day<br>2nd - 4 days<br>3rd - 7 days | 1 day (Med) | 225.39 |
| 52 | Breast | | 1st - 7 days<br>2nd - 1 day<br>3rd - 7 days | 7 days (Med) | 1,577.73 |
| 53 | Prostate | | 1st - 1 day<br>2nd - 5 days | 1 day (CCU) | 346.12 |
| 54 | Lung | | 1st - 11 days<br>2nd - 1 day<br>3rd - 3 days | 1 day (Med)<br>10 days (ICU) | 8,655.60 |
| 55 | Lung | | 1st - 3 days | 1 day (CCU)<br>2 days (ICU) | 2,077.04 |
| 56 | Cloacogenic | | 1st - 5 days<br>2nd - 15 days<br>3rd - 12 days<br>4th - 1 day<br>5th - 15 days | 5 days (ONC) | 1,673.75 |

| | | | | | |
|---|---|---|---|---|---|
| 57 | Lung (Post) | COPD | 1st - 10 days<br>2nd - 19 days<br>3rd - 10 days | 10 days (CCU) | 3,461.20 |
| 58 | Lung | | 1st - 18 days | 18 days (Med) | 4,057.02 |
| 59 | | Atheroclerosis | 1st - 13 days<br>2nd - 23 days | 2 days (CCU)<br>11 days (ICU) | 11,631.52 |
| 60 | Lung | | 1st - 9 days<br>2nd - 13 days | 9 days (Med) | 2,028.51 |
| 61 | Lymphoma | | 1st - 5 days<br>2nd - 6 days<br>3rd - 1 day<br>4th - 1 day<br>5th - 12 days | 5 days (Hem) | 1,673.75 |
| 62 | Tongue | | 1st - 108 days | 74 days (ENT)<br>34 days (ICU) | 54,094.98 |
| 63 | | Diabetes | 1st - 16 days<br>2nd - 3 days<br>3rd - 23 days | 5 days (Med)<br>8 days (ICU)<br>3 days (CCU) | 9.089.79 |
| 64 | Lung | | 1st - 1 day<br>2nd - 9 days | 1 day (ONC) | 334.75 |
| 65 | | MI | 1st - 1 day<br>2nd - 6 days<br>3rd - 3 days<br>4th - 5 days<br>5th - 2 days<br>6th - 9 days | 1 day (CCU) | 346.12 |

| | | | | | |
|---|---|---|---|---|---|
| 66 | Larynx | | 1st - 3 days<br>2nd - 54 days<br>3rd - 4 days | 3 days (ICU) | 2,983.44 |
| 67 | Colon | | 1st - 6 days<br>2nd - 4 days<br>3rd - 34 days | 3 days (Med)<br>3 days (ICU) | 3,659.61 |
| 68 | Lung | | 1st - 11 days | 11 days (Med) | 2,479.29 |
| 69 | | Cirrhosis | 1st - 28 days | 28 days (Med) | 6,310.92 |
| 70 | Lung | | 1st - 1 day<br>2nd - 2 days<br>3rd - 3 days<br>4th - 3 days | 1 day (Med) | 225.39 |
| 71 | Rectum | | 1st - 31 days | 31 days (Med) | 6,987.09 |
| 72 | Endometrium | | 1st - 28 days | 28 days (ONC) | 9,373.00 |
| 73 | | Cirrhosis | 1st - 31 days | 5 days (CCU)<br>20 days (Med)<br>(Incomplete Data) | 6,238.40 |
| 74 | Lymphoma | | 1st - 11 days<br>2nd - 3 days | 4 days (ICU)<br>7 days (Med) | 5,039.97 |
| 75 | Leukemia | | 1st - 20 days<br>2nd - 1 day<br>3rd - 2 days<br>4th - 1 day | 20 days (Med) | 4,507.80 |
| 76 | Thyroid | | 1st - 1 day<br>2nd - 23 days<br>3rd - 2 days<br>4th - 11 days | 1 day (Med) | 225.39 |

| | | | | | |
|---|---|---|---|---|---|
| 77 | | Heart | 1st - 32 days<br>2nd - 5 days<br>3rd - 9 days | 30 days (Med)<br>2 days (CCU) | 7,453.94 |
| 78 | Primary Unknown Liver/Pelvic | | 1st - 11 day<br>2nd - 2 days<br>3rd - 1 day | 11 days (ONC) | 3,682.25 |
| 79 | Gastric | | 1st - 10 days<br>2nd - 1 day<br>3rd - 6 days<br>4th - 1 day | 10 days (Med) | 2,253.90 |
| 80 | | Ulcer | 1st - 44 days<br>2nd - 31 days | 41 days (Med)<br>3 days (CCU) | 10,279.35 |
| 81 | | Cirrhosis | 1st - 9 days<br>2nd - 29 days | 9 days (Med) | 2,028.51 |
| 82 | Sigmoid | | 1st - 23 days | 18 days (Gen Surg)<br>2 days (CCU)<br>3 days (ICU) | 8,609.30 |
| 83 | Esophagus | | 1st - 4 days | 4 days (ONC) | 1,339.00 |
| 84 | Lung | | 1st - 8 days | 8 days (Med) | 1,803.12 |
| 85 | Breast | | 1st - 13 days<br>2nd - 7 days | 13 days (Med) | 2,930.07 |
| 86 | | Heart | 1st - 14 days | 11 days (Med)<br>3 days (CCU) | 3,517.65 |
| 87 | Leukemia | | 1st - 18 days | 16 days (Med)<br>2 days (CCU) | 4,298.48 |

| | | | | | |
|---|---|---|---|---|---|
| 88 | Lung | | 1st - 44 days<br>2nd - 4 days | 44 days (Med) | 9,917.16 |
| 89 | Esophagus | | 1st - 26 days<br>2nd - 37 days | 26 days (GS) | 7,126.34 |
| 90 | | Cirrhosis | 1st - 18 days | 18 days (Med) | 4,057.02 |
| 91 | Bronchogenic | | 1st - 1 day<br>2nd - 5 days<br>3rd - 1 day | 1 day (ICU) | 865.56 |
| 92 | Lung | | 1st - 12 days<br>2nd - 8 days<br>3rd - 1 day<br>4th - 6 days<br>5th - 9 days<br>6th - 18 days | 12 days (Med) | 2,704.68 |
| 93 | | Liver Disease and Colitis | 1st - 17 days<br>2nd - 10 days<br>3rd - 8 days<br>4th - 2 days | 17 days (Med) | 3,831.63 |
| 94 | Bladder | | 1st - 38 days | 38 days (Med) | 8,564.82 |
| 95 | | Renal Failure<br>Diabetes<br>Heart Block | 1st - 1 day<br>2nd - 8 days<br>3rd - 11 days<br>4th - 8 days<br>5th - 7 days<br>6th - 3 days<br>7th - 2 days<br>8th - 11 days | 1 day (CCU) | 346.12 |
| 96 | | Liver Disease | 1st - 10 days | 10 days (Med) | 2,253.90 |

| | | | | | |
|---|---|---|---|---|---|
| 97 | | Cachexia, Sepsis, GI Bleed | 1st - 26 days | 26 days (Med) | 5,860.14 |
| 98 | Lung | | 1st - 3 days<br>2nd - 32 days | 3 days (ONC) | 1,004.25 |
| 99 | | Resp and Renal Failure Due to Sepsis | 1st - 61 days | 7 days (Med)<br>9 days (ICU)<br>45 days (CCU) | 26,103.45 |
| 100 | | COPD | 1st - 8 days<br>2nd - 10 days | 8 days (Med) | 1,803.12 |
| 101 | Cervix (U) | | 1st - 1 day<br>2nd - 1 day<br>3rd - 1 day<br>4th - 8 days<br>5th - 1 day<br>6th - 1 day<br>7th - 1 day<br>8th - 11 days<br>9th - 4 days | 1 day (Gyn) | 290.85 |
| 102 | | Heart | 1st - 7 days<br>2nd - 4 days | 5 days (Med)<br>2 days (CCU) | 1,819.19 |
| 103 | | ASHD | 1st - 12 days<br>2nd - 42 days | 3 days (Med)<br>2 days (CCU)<br>7 days (ICU) | 7,427.33 |
| 104 | Leukemia | | 1st - 16 days<br>2nd - 1 day | 14 days (Med)<br>2 days (ICU) | 4,886.58 |
| 105 | Lung | | 1st - 28 days | 28 days (Med) | 6,310.92 |

| | | | | | |
|---|---|---|---|---|---|
| 106 | | Heart | 1st - 1 day<br>2nd - 16 days<br>3rd - 11 days<br>4th - 13 days | 1 day (CCU) | 346.12 |
| 107 | Esophagus | | 1st - 47 days | 15 days (T-Surg)<br>32 days (ICU) | 35,692.46 |
| 108 | | Ulcer | 1st - 9 days | 9 days (ICU) | 8,950.32 |
| 109 | Lung | | 1st - 1 day<br>2nd - 2 days<br>3rd - 2 days<br>4th - 2 days | 1 day (ICU) | 865.56 |
| 110 | Lung | | 1st - 15 days | 15 days (Med) | 3,380.85 |
| 111 | Renal | | 1st - 11 days<br>2nd - 13 days<br>3rd - 12 days<br>4th - 25 days<br>5th - 6 days<br>6th - 9 days | 11 days (ONC) | 3,682.25 |
| 112 | Tongue | | 1st - 7 days<br>2nd - 84 days | 7 days (ENT) | 1,918.63 |
| 113 | | Heart | 1st - 7 days<br>2nd - 13 days<br>3rd - 2 days<br>4th - 6 days<br>5th - 5 days<br>6th - 9 days | 7 days (CCU) | 2,422.14 |

| | | | | | |
|---|---|---|---|---|---|
| 114 | Lung | | 1st - 4 days<br>2nd - 4 days<br>3rd - 7 days<br>4th - 1 day | 4 days (ONC) | 1,339.00 |
| 115 | Colon | | 1st - 24 days | 24 days (G-Surg) | 6,578.16 |
| 116 | | Heart<br>Diabetes | 1st - 7 days<br>2nd - 10 days<br>3rd - 19 days<br>4th - 44 days<br>5th - 3 days<br>6th - 6 days<br>7th - 9 days | 7 days (CCU) | 2,422.84 |
| 117 | Neck | | 1st - 56 days<br>2nd - 4 days<br>3rd - 4 days | Incomplete data | |
| 118 | | Liver & Renal<br>Failure | 1st - 20 days<br>2nd - 11 days | 3 days (Gen Surg)<br>17 days (ICU) | 15,530.08 |
| 119 | Cecum | | 1st - 13 days | 13 days (Med) | 2,930.07 |
| 120 | | Hemorrhage | 1st - 4 days<br>2nd - 14 days<br>3rd - 8 days | 4 days (CCU) | 1,384.48 |
| 121 | Lung | | 1st - 1 day<br>2nd - 9 days<br>3rd - 2 days | 1 day (ONC) | 334.75 |
| 122 | Colon | | 1st - 39 days | 31 days (Gen Surg)<br>8 days (ICU) | 16,452.60 |

| | | | | | |
|---|---|---|---|---|---|
| 123 | Unknown Primary | | 1st - 1 day<br>2nd - 4 days<br>3rd - 1 day<br>4th - 1 day<br>5th - 1 day | 1 day (FP-Med) | 225.39 |
| 124 | Lung | | 1st - 3 days<br>2nd - 11 days<br>3rd - 9 days<br>4th - 3 days | 3 days (Med) | 676.17 |
| 125 | Leukemia | | 1st - 11 days<br>2nd - 14 days<br>3rd - 9 days | 11 days (Med) | 2,479.29 |
| 126 | Breast | | 1st - 16 days<br>2nd - 5 days<br>3rd - 14 days<br>4th - 16 days | 16 days (ONC) | 5,356.00 |
| 127 | Bladder | | 1st - 21 days<br>2nd - 2 days<br>3rd - 41 days<br>4th - 4 days | 21 days (Med) | 4,733.19 |
| 128 | Multiple Myeloma | | Incomplete Data | | |
| 129 | Prostate | | 1st - 6 days<br>2nd - 20 days<br>3rd - 3 days | 6 days (ONC) | 2,008.50 |

| | | | | | |
|---|---|---|---|---|---|
| 130 | Cervix (U) | | 1st - 15 days<br>2nd - 1 day<br>3rd - 18 days<br>4th - 16 days<br>5th - 25 days<br>6th - 2 days<br>7th - 6 days<br>8th - 1 day | 13 days (GYN)<br>2 days (IMC) | 5,604.60 |
| 131 | Lung | | Incomplete Data | | 225.39 |
| 132 | Renal | | 1st - 21 days | 12 days (Gen Surg)<br>9 days (ICU) | 12,266.40 |
| 133 | | Heart | 1st - 1 day<br>2nd - 4 days<br>3rd - 21 days | 1 day (CCU) | 346.12 |
| 134 | Prostate | | 1st - 4 days<br>2nd - 2 days<br>3rd - 2 days<br>4th - No Record | 8 days (Med) | 1,803.12 |
| 135 | | Heart<br>Myeloid | 1st - 3 days<br>2nd - No Record | 3 days (Card) | 618.15 |
| 136 | | Metaplasia | 1st - 2 days<br>2nd - 2 days<br>3rd - 1 day<br>4th - No Record | 2 days (ONC) | 669.50 |

# APPENDIX B

## UCA COSTS, 1st Quarter, FY 1982

APPENDIX B

UCA COSTS
1st Quarter, FY 1982

| ACCT | DESCRIPTION | COST PER OCCUPIED BED DAY |
|---|---|---|
| AAA | Internal Medicine | 225.39 |
| AAB | Cardiology | 206.05 |
| AAC | Coronary Care | 346.12 |
| AAD | Dermatology | 194.77 |
| AAE | Endocrinology | 301.38 |
| AAF | Gastroenterology | 203.44 |
| AAG | Hematology | --- |
| AAH | Intensive Care (Medical) | 865.56 |
| AAI | Nephrology | --- |
| AAJ | Neurology | 244.27 |
| AAK | Oncology | 334.75 |
| AAL | Pulmonary/Upper Respiratory Disease | 722.14 |
| AAM | Rheumatology | 229.26 |
| AAX | Cost Pools | --- |
| ABA | General Surgery | 274.09 |
| ABB | Cardiovascular and Thoracic Surgery | 257.94 |
| ABC | Intensive Care (Surgical) | 994.48 |
| ABD | Neurosurgery | 212.35 |
| ABE | Ophthalmology | 246.04 |
| ABF | Oral Surgery | 278.79 |
| ABG | Otorhinolaryngology | 331.37 |
| ABH | Pediatric Surgery | 174.30 |
| ABI | Plastic Surgery | 264.48 |
| ABJ | Proctology | --- |
| ABK | Urology | 297.96 |
| ABX | Cost Pools | --- |
| ACA | Gynecology | 290.85 |
| ACB | Obstetrics | 245.38 |
| ACX | Cost Pools | --- |
| ADA | Pediatrics | 300.53 |

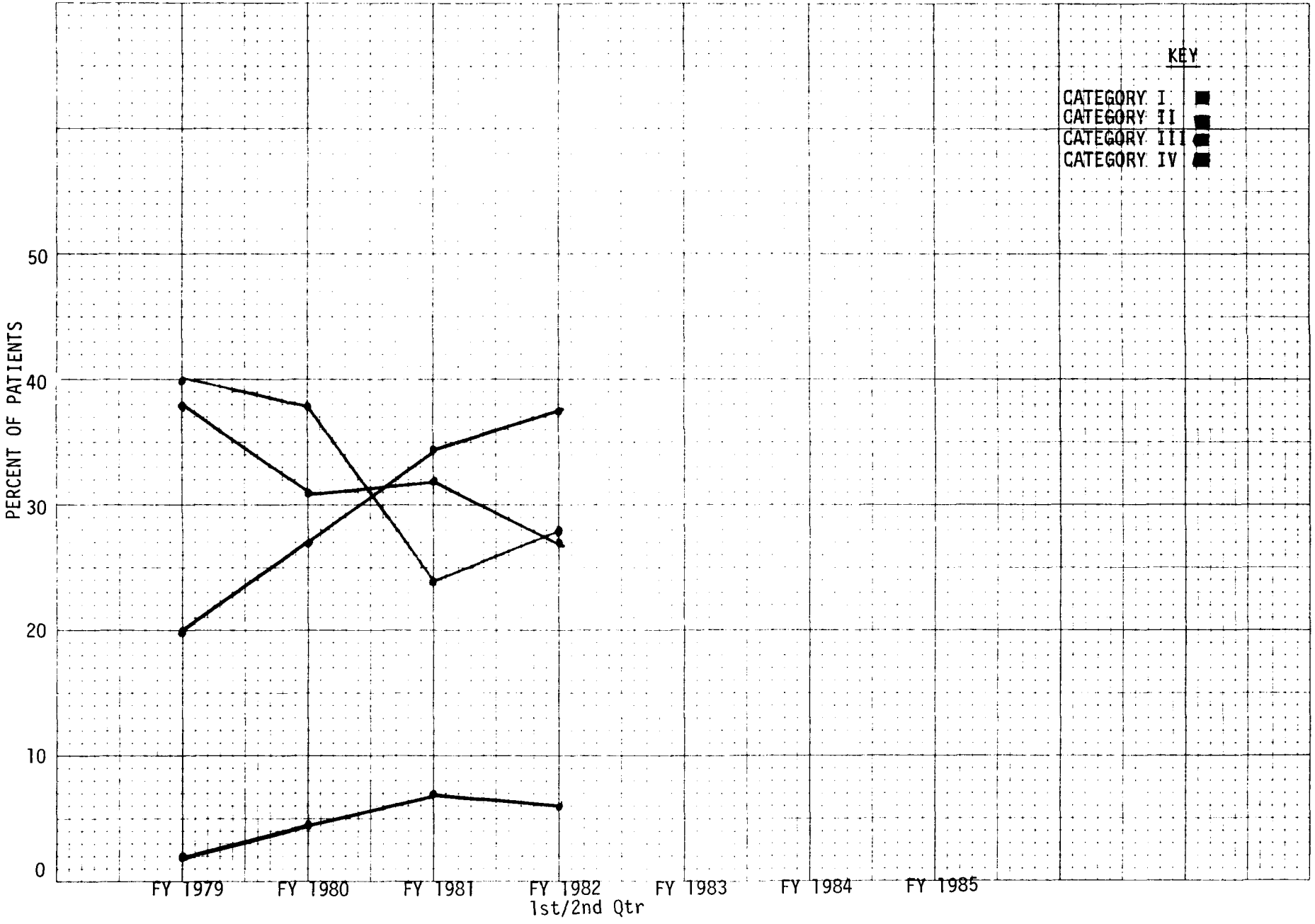
APPENDIX C

DISTRIBUTION OF PATIENTS BY CATEGORY
FOR FY 79, 80, 81, 82

NO 340-10 DIETZGEN GRAPH PAPER
10 X 10 PER INCH
DIETZGEN CORPORATION
MADE IN U.S.A.

APPENDIX C

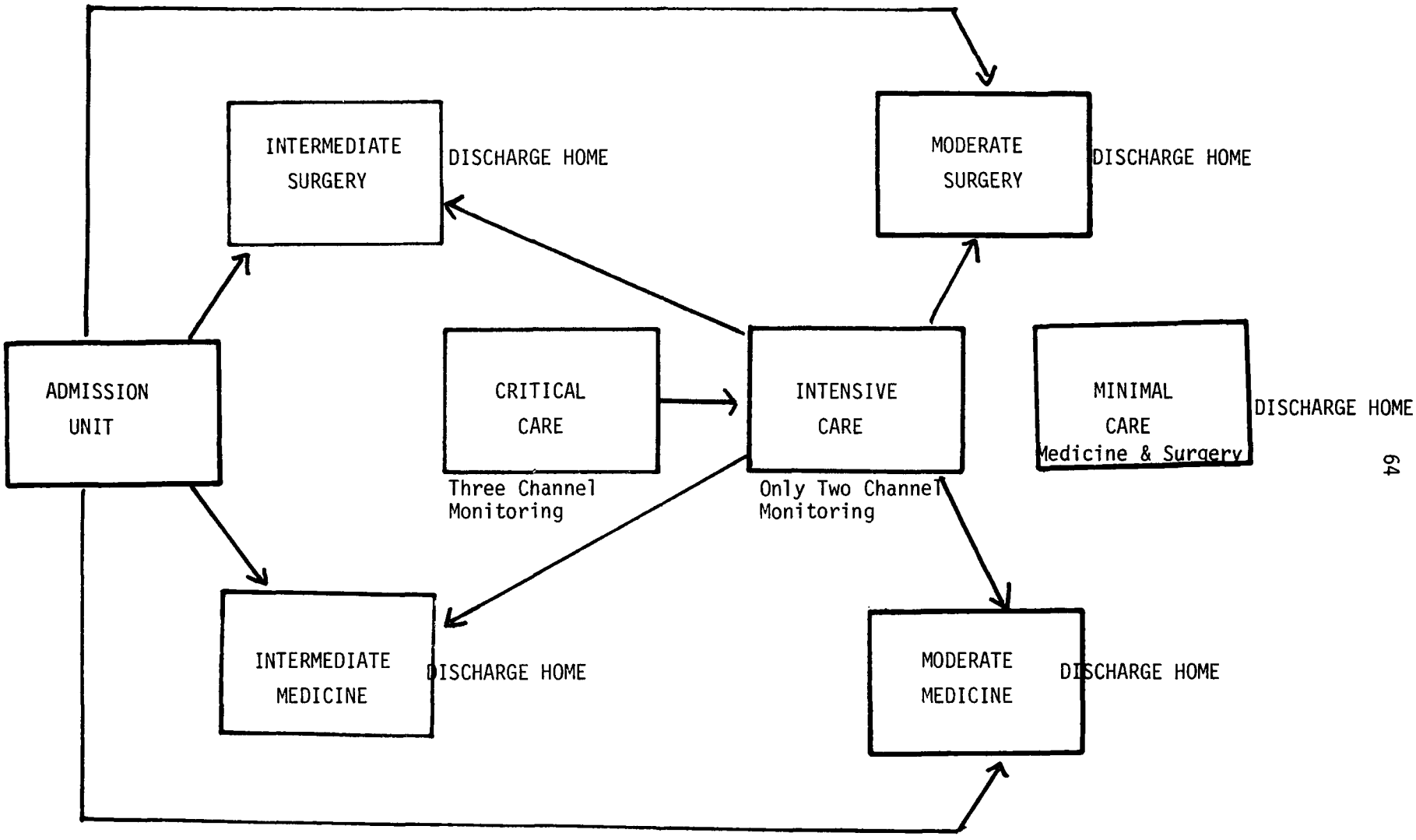
DISTRIBUTION OF PATIENTS BY CATEGORY FOR FY 79, 80, 81, 82



# APPENDIX D

## MADIGAN ARMY MEDICAL CENTER ACUITY PROGRESSION

APPENDIX D
MADIGAN ARMY MEDICAL CENTER ACUITY PROGRESSION




STAFFING COMMENSURATE WITH ACUITY
EXCEPTIONS: PSYCHIATRY, PEDIATRICS, OBSTETRICS

# APPENDIX E

## SOCIAL WORK PLACEMENT STATISTICS

APPENDIX E

SOCIAL WORK PLACEMENT STATISTICS
CHRONICALLY DEBILITATED PATIENTS
May 1981 - March 1982

| | PATIENT | DIAGNOSIS | TIMES ADMITTED TO MAMC (Since March D/C) | CANDIDATE FOR HOSPICE CARE - DISCHARGED HOME |
|---|---|---|---|---|
| March 1982 | A | OBS/ETOHism | 0 | Discharged home as family could not afford hospice. |
| | B | Multiple Med problems; Cirrhosis, Incompetent, ETOHism | 0 | Family cannot afford hospice care. |
| | C | Sepsis, CHF, RRF | 0 | Discharged to nursing home because hospice not available. |
| | D | Breast CA & multiple med problems | 0 | Discharged to nursing home as hospice not available. |
| | | | (Since Feb D/C) | |
| February 1982 | E | Stroke, Prostate CA | 1 | Patient cannot afford hospice care. |
| | F | Colon CA | * | Patient cannot afford hospice care. |
| | G | OBS, Prostate CA | * | Discharged to nursing home as hospice not available. |
| | H | Incompetent, ETOHism | 0 | Family cannot afford hospice care. |
| | I | COPD, ETOHism | 0 | Patient cannot afford hospice care. |

*No Record

| | PATIENT | DIAGNOSIS | TIMES ADMITTED TO MAMC | DISCHARGED HOME |
|---|---|---|---|---|
| | | | (Since Jan 82 D/C) | |
| January 1982 | J | Lung CA | 2-Jan/1-Mar | Patient cannot afford hospice care. |
| | K | CA | 2-Jan/1-Feb | Family could not afford hospice care. |
| | L | CA | 1 | Family could not afford hospice care. |
| | M | OBS | Expired at MAMC | Family could not afford hospice care; deceased at MAMC. |
| | N | Brain Tumor | 0 | Family cannot afford hospice care. |
| | O | Unknown | 2 (Deceased Jan) | Hospice care not available nor could patient afford; deceased at MAMC. |
| | P | Multiple AODM, COPD | 0 | Patient could not afford hospice care. |
| | | | (Since Dec 81 D/C) | |
| December 1981 | Q | CA | 0 | Family cannot afford hospice care. |
| | R | CA | Expired 13 Dec 81 | Family could not afford hospice care. |
| | S | Lung CA | 2 | Family could not afford hospice care. |
| | T | CA | 0 | Family could not afford hospice care. |
| | U | CA | 0 | Patient could not afford hospice care. |
| | V | CA | 4 | Family could not afford hospice care. |
| | W | ETOHism | 0 | Patient could not afford hospice care. |

| | PATIENT | DIAGNOSIS | TIMES ADMITTED TO MAMC (Since Nov 81 D/C) | CANDIDATE FOR HOSPICE CARE - DISCHARGED HOME |
|---|---|---|---|---|
| November 1981 | X | Heart Disease | | Patient deceased at MAMC; hospice care not available. |
| | Y | Diabetic, ETOHism | 0 | Family could not afford hospice care. |
| | Z | CA | Expired at MAMC | Family could not afford hospice care; patient deceased at MAMC. |
| | AA | Cardiac Arrest | Expired at MAMC | Patient deceased at MAMC; hospice care not available. |
| | BB | Cranial Met. | 1 | Family could not afford hospice care. |
| | CC | ETOHism, GI Bleed | 0 | Patient could not afford hospice care. |
| | DD | Lung CA | 0 | Family could not afford hospice care. |
| | EE | Unknown | Expired at MAMC | Hospice not available; patient deceased at MAMC. |
| | FF | Tumor-Pancrease | 2 | Family could not afford hospice care. |
| | GG | Senility, Multiple Strokes | 1 | Family could not afford hospice care. |
| October 1981 | HH | CA, Dementia | 2 (Deceased 3 Jan) | Family could not afford hospice care. |
| | II | Modular Lymphoma | 2 (Deceased 5 Jan) | Family could not afford hospice care. |
| | JJ | Severe COPD | 0 | Family could not afford hospice care. |

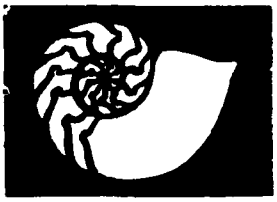
| | PATIENT | DIAGNOSIS | TIMES ADMITTED TO MAMC | CANDIDATE FOR HOSPICE CARE - DISCHARGED HOME |
|---|---|---|---|---|
| | KK | Cirrhosis | Expired at MAMC | Hospice care not available; patient deceased at MAMC. |
| | LL | Metastatic Brain Tumor | 1 | Family could not afford hospice care. |
| | MM | Alcohol | 0 | Discharged to nursing home as hospice not available. |
| | NN | ASPVD | 0 | Discharged home. Family could not afford hospice. |
| | OO | Dementia | 0 | Discharged to nursing home as hospice not available. |
| | PP | Diabetes, Osteoporosis | 0 | Discharged home; family could not afford hospice. |
| September 1981 | QQ | CA Lung | (Since Sep 81 D/C) 0 (Deceased 23 Sep) | Discharged home; family could not afford hospice. |
| | RR | Diabetes | 0 | Discharged home; family could not afford hospice. |
| | SS | Unknown | 2 | Discharged home; family could not afford hospice. |
| | TT | Unknown | Expired at MAMC | Patient deceased at MAMC; hospice not available. |
| | UU | Degen. Joint Disease | 0 | Patient discharged to nursing home as hospice not available. |
| | VV | Unknown | Expired at MAMC | Patient deceased at MAMC; hospice not available. |
| | WW | Sick Sinus Syndrome | 1 | Discharged to nursing home; hospice not available. |

| | PATIENT | DIAGNOSIS | TIMES ADMITTED TO MAMC | CANDIDATE FOR HOSPICE CARE - DISCHARGED HOME |
|---|---|---|---|---|
| | XX | Unknown | Expired at MAMC | Patient deceased at MAMC; hospice not available |
| | | | (Since Aug 81 D/C) | |
| August 1981 | YY | ASHD | 2 | Discharged to nursing home; hospice not available |
| | ZZ | ASPVD | 0 | Discharged home; family could not afford hospice. |
| | AAA | Alcoholic; Liver Disease | 0 | Discharged home; family could not afford hospice. |
| | BBB | Fractures, leg malleolus | 0 | Discharged home; family could not afford hospice. |
| | CCC | Diabetes | 0 | Discharged to nursing home as hospice not available. |
| | DDD | Unknown | 1 (Deceased Oct.) | Discharged home; family could not afford hospice. |
| | EEE | Diabetes | 0 | Discharged home; family could not afford hospice. |
| May-July 1981 | FFF | Unknown | (Since May 81 D/C) | Patient deceased at MAMC; hospice not available. |
| | GGG | Diabetes | 2 | Transferred to ICF as hospice not available. |
| | HHH | Unknown | Expired at MAMC | Patient deceased at MAMC; hospice not available. |
| | III | Unknown | 0 | Discharged to nursing home; hospice not available. |

| PATIENT | DIAGNOSIS | TIMES ADMITTED TO MAMC | CANDIDATE FOR HOSPICE CARE - DISCHARGED HOME |
|---|---|---|---|
| JJJ | Unknown | Deceased at MAMC | Patient deceased at MAMC, as hospice not available. |
| KKK | CVA | 1-Jul/1-Aug | Transferred to Good Samaritan, hospice not available. |
| LLL | Unknown | Deceased at MAMC | Patient deceased at MAMC, as hospice not available. |
| MMM | CHF & ASHD | 3 | Discharged home as family could not afford hospice. |
| NNN | Coronary Artery Disease | 1 | Discharged to nursing home as hospice not available. |
| OOO | Heart Disease | 0 | Discharged to nursing home as hospice not available. |
| PPP | Injury, Head | 1 | Discharged home, as family could not afford hospice. |
| QQQ | Unknown | Deceased at MAMC | Patient deceased at MAMC, as hospice not available. |
| RRR | Unknown | 5 (Deceased Oct) | Discharged home; family could not afford hospice. |
| SSS | CA | 1 | Discharged home; family could not afford hospice. |
| TTT | Unknown | Deceased at MAMC | Patient deceased at MAMC as hospice not available. |
| UUU | CA, Lip | 1 | Discharged to nursing home as hospice not available. |

APPENDIX F

COST STUDY
HOSPICE OF THE MONTEREY PENINSULA



HOSPICE
*of the*
MONTEREY
PENINSULA

*A non profit corporation providing support to patients with life threatening illness.*

# C O S T  S T U D Y

for

INPATIENT FACILITY

Prepared by:

Barbara Smythe
Raymond Decker

November 18, 1981

| | | TOTAL |
|---|---|---|
| **EMPLOYEE COSTS** | | |
| Salaries | | |
| 01 Permanent Employees | | |
| - Medical Director | | $ 50,000 |
| - Director of Patient Care | | 20,000 |
| - Hospice Nurse ( 3 @ 20,000) | | 60,000 |
| - Hospice Caregiver (3 @ 14,412) | | 43,236 |
| - Cook ( 2080 hrs @ 3.80 hr) | | 7,904 |
| - Housekeeper(@ 3.75 hr) | | 7,800 |
| - Receptionist | | 9,300 |
| | | 198.240 |
| 02 Part Time Employees | | |
| - Hospice Nurse (3/3280 hrs @ 9.60 hr) | | 31,488 |
| - Hospice Caregiver (3/3280 hrs @ 6.90 hr) | | 22,632 |
| - Cook (1100 hrs @ 3.80 hr) | | 4,180 |
| - Billing Clerk (20 hrs @ 6.00 hr) | | 6,240 |
| - Building Maintenance Engineer( 75% of 825. month) | | 7,425 |
| | | 71,965 |
| Total Salaries | | $270,205 |
| Fringe Benefits | | |
| 04 Pension Plan (5% gross payroll) | | 13,510 |
| 05 Social Sec. (6.70% in lieu of) | | 16,763 |
| 06 State Unemployment Ins.(3.5% $6000) | | 4,136 |
| 07 Worker's Compensation Ins. | | 19,615 |
| 08 Health Ins. (Est. 11 at 80/mo.) | | 10,560 |
| Total Fringe Benefits | | $ 64,584 |
| **TOTAL EMPLOYEE COSTS** | | $334,789 |
| **OPERATING AND MAINTENANCE** | | |
| 10 Training | | 1,500 |
| 11 Travel (4000 miles at .25¢) | | 1,000 |
| 12 Consultations | | |
| - Dietician (@ 125. monthly) | 1,500 | |
| - Occupational Therapist (8 hrs wk @ 25. per hr) | 2,400 | |
| - Physical Therapist (5 hrs wk @ 40. per hr) | 10,400 | 14,400 |
| 15 Office Expense - postage | | 300 |
| 16 Office Expense - Other | | |
| -Expendable Office Supplies, Maintenance & Equipment | | 1,000 |

| | | | TOTAL |
|---|---|---|---|
| **OPERATING AND MAINTENANCE** | | | |
| 17 | Books and Periodicals<br>- Newspaper, Magazines, Patient use, Nursing Publications | | 1,000 |
| 18 | Duplication & Printing | | |
| | - Miscellaneous Forms | 500 | |
| | - Name Pins & Identification | 200 | |
| | - Copier Usage | 200 | |
| | | | 900 |
| 20 | Household - Food (5.00 per day) | | 10,950 |
| 21 | Household - Supplies | | 2,000 |
| 22 | Pool Supply & Maintenance | | 1,200 |
| 23 | Medical Supplies<br>- Oxygen, Medications, etc. | | 4,000 |
| 24 | Grounds - Supply & Maintenance | 3,000 | |
| | Gardner (@ 400. mo) | 4,800 | 7,800 |
| 25 | Telephone | | |
| | - Monthly Service | 2,000 | |
| | - Pager for Coordinator | 300 | 2,300 |
| 26 | Utilities | | |
| | - P.G.& E. (90%) | 2,000 | |
| | - Disposal (90%) | 300 | |
| | - Cal Am Water (90) | 200 | |
| | - Bottled Water | 300 | |
| | - TV Cable | 300 | 3,100 |
| 27 | Fees and Licenses | | 1,500 |
| 30 | Mortgage Payments (90%) | | |
| | - Monterey Saving & Loan | 22,896 | |
| | - Ruben et al | 3,690 | 26,586 |
| 33 | Insurance (90%) | | |
| | - Building Contents | 927 | |
| | - Professional Liability Umbrella | 1,800 | 2,727 |
| **TOTAL OPERATING & MAINTENANCE** | | | 82,163 |
| **CAPITAL OUTLAY** | | | |
| 51 | Building<br>- Electrical/Plumbing Repairs | | 10,000 |

| | | TOTAL |
|---|---|---|
| *CAPITAL OUTLAY* | | |
| 53 *Furniture and Equipment* | | |
| - *Nursing Station-Desk* | 300 | |
| - *Nursing Station-Typewriter* | 700 | |
| - *Nursing Station-File Cabinet* | 195 | |
| - *Industrial Vacuum Cleaner* | 300 | |
| - *Examining Room:* | | |
| *Examining Table* | 1,000 | |
| *Supply Cabinet* | 200 | |
| *Stool* | 95 | |
| *Lamp* | 100 | 2,890 |
| *TOTAL CAPITAL OUTLAY* | | 12,890 |
| *TOTAL COST* | | $429,842 |

## PER DAY COST PER PATIENT

A. WITH TOTAL BUDGET COST PER DAY PER PATIENT . . . . . $196.27

B. POSSIBLE CUTBACKS: (Dollar amounts represent savings.)

| | | |
|---|---|---|
| 1. | Receptionist | 9,300 |
| 2. | One-half time building Maintenenace Engineer | 2,475 |
| 3. | Medical Director, part-time | 40,000 |
| 4. | 1 Nurse and 5 care-givers per 24 hours | 11,176 |
| 5. | Medical Supplies billed to individual patients | 4,000 |
| 6. | Physical Therapist billed to individual patients | 10,400 |
| 7. | Occupational Therapist billed to individual patients | 2,400 |
| 8. | Capital Outlay | 12,890 |
| | | 92,641 |

C. COST PER DAY PER PATIENT WITH VARIATIONS IN CUTBACKS:

| | | |
|---|---|---|
| 1. | Given cutback of B1 only | 192.03 |
| 2. | " " " B2 only | 195.14 |
| 3. | " " " B3 only | 178.00 |
| 4. | " " " B4 only | 191.17 |
| 5. | " " " B5 only | 194.45 |
| 6. | " " " B6 only | 191.52 |
| 7. | " " " B7 only | 195.18 |
| 8. | " " " B8 only | 190.39 |
| 9. | " " " B5, 6 & 7 | 188.60 |
| 10. | " " " B6, 6, 7 & 8 | 182.72 |
| 11. | " " " B4, 5, 6, 7 & 8 | 177.61 |
| 12. | " " " B3, 4, 5, 6, 7 & 8 | 159.34 |
| 13. | " " " B2, 3, 4, 5, 6, 7 & 8 | 158.22 |
| 14. | Given all the cutbacks B1 thru 8 | 153.97 |

# APPENDIX G

## PROPOSED PROGRAM AND BUDGET REPORT
## HOSPICE OF THE MONTEREY PENINSULA

HOSPICE
*of the*
MONTEREY
PENINSULA

*A non profit corporation providing support to patients with life threatening illness.*

# PROPOSED PROGRAM AND BUDGET REPORT

FOR THE FISCAL YEAR

JULY 1, 1981 through JUNE 30, 1982

Submitted to

BOARD OF DIRECTORS

June 15, 1981

by

RAYMOND G. DECKER, Executive Director

In collaboration with:

Jerome L. Rubin, M.D., Medical Director
Jan Hinton, Administrative Assistant
Karin Sobeck, Home Care Director
Laurette Toldi, Volunteer Coordinator
Sabra Hudson, Special Services Coordinator
John Olsen, Bookkeeper
John O. Ahern, Director of Financial Development
and Public Relations

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* * *

*PROGRAM REPORT FOR FISCAL YEAR 1981-82*

*-Comprehensive Program-*

*Definition:* *Comprehensive Program is herein defined as the governing goals and objectives which give direction and establish priorities for expenditures in all the activities undertaken by Hospice for the fiscal year of 1981-82.*

*Goal:* *To expand without deficit spending the number and quality of services of a specialized program which provides medical, social, psychological and spiritual care to patients faced with life threatening illnesses and their families.*

*Objectives:*

1. *To expand the present home care services.*
2. *To open the inpatient facility by July 1, 1981. and integrate it with the home care services.*
3. *To expand volunteer services in all areas:*
   a. *Patient care*
   b. *Office workers*
   c. *Transportation*
   d. *Housekeeping*
   e. *Gardening*
4. *To provide better integrated services in the areas of:*
   a. *Bereavement*
   b. *Spiritual and/or pastoral support*
5. *To restructure the administrative organization of Hospice in order to clarify lines of accountability and communications by reviewing:*
   a. *Personnel policies*
   b. *Organizational charts*
6. *To do a cost analysis study which will enable Hospice to reduce costs and so function without an operational deficit for the fiscal year of 1981-82.*
7. *To expand the development program so that it will be able to eliminate the deficit between actual costs and reimbursements.*

# HOSPICE OF THE MONTEREY PENINSULA
## Proposed Budget 1981-82

### Comprehensive Budget

| | | |
|---|---|---|
| General Fund Balance as of July 1, 1981 | | $ 85,000. |
| Restricted Funds | | 20,500. |
| Current Funds Available | | $105,500. |
| REVENUES FOR 1981-82 | | |
| Reimbursement for Services: | | |
| Home Care | $ 50,000. | |
| Inpatient | 105,000. | |
| Total: | $155,000. | |
| County Social & Culture Contract | 5,200. | |
| General Donations | 15,000. | |
| Memorials | 30,000. | |
| Ad hoc drive | 105,000. | |
| Matching Funds | 225,000. | |
| Net proceeds from special events | 10,000. | |
| Investment Income | 2,500. | |
| Other Revenues | 100. | |
| Total 1981-82 Revenues | | 547,800. |
| Total Funds Available | | $653,300. |

EXPENDITURES FOR 1981-82

| | Department Request | Recommended Executive Request | Fiscal Mgt. Committee |
|---|---|---|---|
| Administration #400 | $ 95,850. | $ 95,850. | |
| Volunteers #401 | 27,823. | 27,823. | |
| Financial Development and Public Relations #402 | 33,067. | 33,067. | |
| Special Services #403 | 8,588. | 8,588. | |
| Cancer Support Group #404 | 3,740. | 3,740. | |
| Resource information Center #405 | 5,316. | 5,316. | |
| Home Care #420 | 89,186. | 89,186. | |
| Inpatient Facility #410 | 351,081. | 351,081. | |
| Total Expenditures | $614,651. | $614,651. | |
| Fund Balances June 30, 1982 | $ 38,649. | $ 38,649. | |

## *DIVISIONAL PROGRAMS*

### *-Administration-*
### *(400)*

*Goal:* *To administer and coordinate all activities of Hospice so that they are mutually supportive and enabled to expand without deficit spending.*

*Objectives:*

1. *To work with the Committee on Fiscal Management in order to achieve a balanced operational budget for the fiscal year of 1981-82 by:*
   a. *Doing a study to ascertain the cost structure of Hospice and to decide where costs may be reduced.*
   b. *Negotiating maximum reimbursement schedules for both home care and inpatient facility with third-party providers.*
2. *To work with the Committee on Financial Development and Public Relations in order to expand the financial development program so that it will provide for:*
   a. *The deficit between actual costs and reimbursement.*
   b. *Elimination of present capital and operational indebtedness.*
   c. *A capital fund for future expansion.*
3. *To work with the Committee on Organizational Development and Accreditation in order to delineate more clearly the lines of accountability and communications within the organizational structure by reviewing and revamping where necessary:*
   a. *Personnel policies*
   b. *Organizational charts*
4. *To administer and coordinate the day-to-day operations of Hospice.*

HOSPICE OF THE MONTEREY PENINSULA
proposed Budget 1981-82

Administration Account #400

| | Department Request | Recommended Executive Request | Recommended Fiscal Mgt. Committee |
|---|---|---|---|
| EMPLOYEE COSTS | | | |
| Salaries: | | | |
| 01 Permanent Employees | | | |
| -Executive Director | $25,000. | $25,000. | |
| -Administrative Assistant | 17,808. | 17,808. | |
| -Accountant | 15,000. | 15,000. | |
| | $57,808. | $57,808. | |
| 02 Part Time Employees | | | |
| -Bookkeeper/Typist | 4,800. | 4,800. | |
| Total Salaries | $62,608. | $62,608. | |
| Fringe Benefits: | | | |
| 04 Pension Plan (5% gross payroll) | $ 3,130. | $ 3,130. | |
| 05 Social Security (6.65% in lieu of) | 4,163. | 4,163. | |
| 06 State Unemployment Ins. (3.5%/$6000) | 798. | 798. | |
| 07 Worker's Compensation Ins. (0.43%) | 269. | 269. | |
| 08 Health Ins. ($80.00 per employee month) | 2,880. | 2,880. | |
| Total Fringe Benefits | $11,240. | $11,240. | |
| Total Employee Costs | $73,848. | $73,848. | |
| OPERATING AND MAINTENANCE | | | |
| 11 Travel (est. 2500 miles/$.20) | $ 500. | $ 500. | |
| 13 Conferences & Meetings -Registration fees, travel and lodging | 600. | 600. | |
| 15 Office Expense - Postage -P.O. Box Rental, thank you notes, etc. | 1,500. | 1,500. | |
| 16 Office Expense - Other -Expendable office supplies maintenance of equip.,etc. | 1,000. | 1,000. | |

HOSPICE OF THE MONTEREY PENINSULA
Proposed Budget 1981-82

Administration Account #400

| | Department Request | Recommended Executive Request | Recommended Fiscal Mgt. Committee |
|---|---|---|---|
| OPERATING AND MAINTENANCE | | | |
| 18 Duplicating & Printing | | | |
| -Copier Maintenance Contract | $ 1,800. | $ 1,800. | |
| -Paper Costs, Copier | 900. | 900. | |
| -Purchase Payments at $186.75 | 2,241. | 2,241. | |
| -Letterheads | 225. | 225. | |
| -Envelopes | 350. | 350. | |
| -Business Cards/Forms | 150. | 150. | |
| | $ 5,666. | $ 5,666. | |
| 25 Telephone (50%) | 2,000. | 2,000. | |
| 26 Utilities | | | |
| -P.G.E (25%) | 600. | 600. | |
| -Disposal (25%) | 100. | 100. | |
| -Cal Am Water (25%) | 20. | 20. | |
| -Bottled Water (50%) | 140. | 140. | |
| | $ 860. | $ 860. | |
| 27 Fees and Licenses | | | |
| -National Hospice Organization | 500. | 500. | |
| -Miscellaneous | 100. | 100. | |
| | $ 600. | $ 600. | |
| 32 Interest | | | |
| -Jerome Rubin ($4000/07%) | $ 280. | $ 280. | |
| 33 Insurance | | | |
| -Building & Contents (25%) | 340. | 340. | |
| -Bond Renewal | 118. | 118. | |
| -Tax & Interest Charges | 188. | 188. | |
| | $ 646. | $ 646. | |
| 39 Miscellaneous | | | |
| -Auditing & Account. Services | $ 2,700. | $ 2,700. | |
| -Personnel Recruitment Costs | 650. | 650. | |
| | $ 3,350. | $ 3,350. | |
| Total Operating & Maintenance | $17,002. | $17,002. | |

HOSPICE OF THE MONTEREY PENINSULA
Proposed Budget 1981-82

Administration Account #400

| | Department Request | Recommended Executive Request | Recommended Fiscal Mgt. Committee |
|---|---|---|---|
| CAPITAL OUTLAY | | | |
| 53 Furniture & Fixtures, Word Processor & Other Equipment | $ 5,000. | $ 5,000. | |
| Total Account #400 | $95,850. | $95,850. | |

## *DIVISIONAL PROGRAMS*

### *-Volunteers-*
### *(401)*

*Goal:* *To expand the present volunteer program to render more diversified services and to reach more patients and their families.*

*Objectives:*

1. *To increase the number of volunteers through concerted recruitment processes.*
2. *To expand the type of services rendered by volunteers to include not only patient care, office workers, and transportation, but also housekeeping and gardening.*
3. *To intensify both the general and specialized training programs for all volunteers.*

HOSPICE OF THE MONTEREY PENINSULA
Proposed Budget 1981-82

Volunteers Account #401

| | Department Request | Recommended Executive Request | Recommended Fiscal Mgt. Committee |
|---|---|---|---|
| EMPLOYEE COSTS | | | |
| Salaries: | | | |
| 01 Permanent Employees -Volunteer Coordinator | $15,264. | $15,264. | |
| 02 Part Time Employees -Typist Clerk | 3,000. | 3,000. | |
| Total Salaries | $18,264. | $18,264. | |
| Fringe Benefits | | | |
| 04 Pension Plan (50% gross Payroll) | 913. | 913. | |
| 05 Social Security (6.65% in lieu of) | 1,215. | 1,215. | |
| 06 State Unemployment Ins. (3.5%/$6000) | 315. | 315. | |
| 07 Worker's Compensation Ins. (0.43%) | 79. | 79. | |
| 08 Health Ins. ($80.00 per month) | 960. | 960. | |
| Total Fringe Benefits | $ 3,482. | $ 3,482. | |
| Total Employee Costs | $21,746. | $21,746. | |
| OPERATING AND MAINTENANCE | | | |
| 10 Training -Conferences, Tuition, Travel | $ 260. | $ 260. | |
| -Univ. Cal. S.F. Course | 1,500. | 1,500. | |
| -Training Films | 200. | 200. | |
| | $ 1,960. | $ 1,960. | |
| 11 Travel (2800 miles/$.20) | 560. | 560. | |
| 12 Consultations -Psychological Counselor at $50 hr/2 hr/every 4 weeks | 1,200. | 1,200. | |
| 15 Office Expense - Postage | 25. | 25. | |

HOSPICE OF THE MONTEREY PENINSULA
Proposed Budget 1981-82

Volunteers Account #401

| | Department Request | Recommended Executive Request | Fiscal Mgt. Committee |
|---|---|---|---|
| OPERATING AND MAINTENANCE | | | |
| 16 Office Expense - Other<br>-General Office Supplies, Bindings for Manuals and Brochures | $ 140. | $ 140. | |
| 17 Books and Periodicals | 150. | 150. | |
| 18 Printing & Duplicating<br>-Copier Usage, Manuals, Brochures, Handouts<br>-Hospice Letterheads<br>-Hospice Envelopes | $ 1,000. | $ 1,000. | |
| 25 Telephone | $ 180. | $ 180. | |
| 30 Rent<br>-Meeting room paid in form of donation to church | $ 100. | $ 100. | |
| 33 Insurance | | | |
| -Umbrella (50%) | $ 450. | $ 450. | |
| -Professional Liability (50%) | 312. | 312. | |
| | $ 762. | $ 762. | |
| Total Operating & Maintenance | $ 6,077. | $ 6,077. | |
| CAPITAL OUTLAY | 0. | 0. | |
| Total Account #401 | $27,823. | $27,823. | |

*DIVISIONAL PROGRAMS*

*-Financial Development and Public Relations-*
*(402)*

*Goal:* *To coordinate programs of increased public education with fund raising so that there is a substantial increment in both community awareness of Hospice and financial contributions.*

*Objectives:*

1. *To increase community awareness of Hospice by increased exposure:*
   a. *on television*
   b. *on radio*
   c. *in newspapers*
   d. *through providing speakers to various organizations in the community.*
2. *To solicit substantial contributions from individual members of the community in collaboration with the Committee on Financial Development and Public Relations.*
3. *To solicit contributions from corporations in the community.*
4. *To solicit grants from foundations particularly interested in the services and goals of Hospice.*
5. *To increase smaller contributions within the community by more exposure through the Newsletter and other mass media means.*
6. *To develop a program of deferred giving in collaboration with lawyers in the community.*

HOSPICE OF THE MONTEREY PENINSULA
Proposed Budget 1981-81

Financial Development & Public Relations Account #402

| | Department Request | Recommended Executive Request | Recommended Fiscal Mgt. Committee |
|---|---|---|---|
| EMPLOYEE COSTS | | | |
| Salaries: | | | |
| 01 Permanent Employees -Director | $15,000. | $15,000. | |
| 02 Part Time Employees -Secretary | 6,000. | 6,000. | |
| Total Salaries | $21,000. | $21,000. | |
| Fringe Benefits: | | | |
| 04 Pension Plan (5% Gross Payroll) | $ 1,050. | $ 1,050. | |
| 05 Social Security (6.65% in lieu of) | 1,397. | 1,397. | |
| 06 State Unemployment Ins. (3.5%/$6000) | 420. | 420. | |
| 07 Worker's Compensation Ins. (0.43%) | 90. | 90. | |
| 08 Health Ins. ($80/mo.) | 960. | 960. | |
| Total Fringe Benefits | $ 3,917. | $ 3,917. | |
| Total Employee Costs | $24,917. | $24,917. | |
| OPERATING AND MAINTENANCE | | | |
| 15 Office Expense - Postage | | | |
| -Monthly Newsletter | $ 1,450. | $ 1,450. | |
| -1981 Fund Drive | 100. | 100. | |
| -Annual Memorial Gift Followup | 50. | 50. | |
| -Year End Community Support Drive | 300. | 300. | |
| | $ 1,900. | $ 1,900. | |
| 16 Office Expense - Other -File Folders | 150. | 150. | |
| 18 Duplicating & Printing | | | |
| -Monthly Newsletter at $250/mo | $ 3,000. | $ 3,000. | |
| -Newsletter Labels/preparation | 600. | 600. | |
| -1981 Fund Drive Materials | 500. | 500. | |
| -Annual Memorial Gift Followup | 250. | 250. | |

HOSPICE OF THE MONTEREY PENINSULA
Proposed Budget 1981-82

Financial Development & Public Relations Account #402

| | Department Request | Recommended Executive Request | Fiscal Mgt. Committee |
|---|---|---|---|
| OPERATING AND MAINTENANCE | | | |
| -Year End Community Support Drive | $ 500. | $ 500. | |
| -Memorial Cards/Donor & Bereaved | 150. | 150. | |
| | $ 5,000. | $ 5,000. | |
| 19 Advertising & Promotion | | | |
| -Monthly PR Luncheons/Hospice | 600. | 600. | |
| -Preparation/Video & Radio tapes for no charge media spots | 500 | 500 | |
| | $ 1,100. | $ 1,100. | |
| Total Operating & Maintenance | $ 8,150. | $ 8,150. | |
| CAPITAL OUTLAY | 0. | 0. | |
| Total Account #402 | $33,067. | $33,067. | |

Note: Special events will be self supporting

## *DIVISIONAL PROGRAMS*

### *-Special Services-*
### *(403)*

*Goal:* *To provide programs for increased clergy participation in the work and services of Hospice and increased bereavement support for families of the community.*

*Objectives:*

1. *To conduct workshops for the clergy of the area to inform them about Hospice.*
2. *To mail information about Hospice to the clergy of the area so that they can keep such on file for future reference.*
3. *To develop a bereavement program which will serve to support families and friends of those who die in the Hospice program.*
4. *To develop a bereavement information pamphlet for distribution at the local mortuaries.*
5. *To provide hospitality for various groups which are interested in knowing about the programs and facility of Hospice.*

HOSPICE OF THE MONTEREY PENINSULA
Proposed Budget 1981-82

Special Services Account #403

| | Department Request | Recommended Executive Request | Recommended Fiscal Mgt. Committee |
|---|---|---|---|
| EMPLOYEE COSTS | | | |
| Salaries: | | | |
| 02 Part Time Coordinator | $ 6,600. | $ 6,600. | |
| Fringe Benefits: | | | |
| 06 State Unemployment Ins. (3.5%/$6000) | 210. | 210. | |
| 07 Worker's Compensation Ins. (0.43%) | 28. | 28. | |
| Total Fringe Benefits | $ 238. | 238. | |
| Total Employee Costs | $ 6,838. | $ 6,838. | |
| OPERATION AND MAINTENANCE | | | |
| 10 Training | $ 250. | $ 250. | |
| 11 Travel (1000 miles at $.20) | 250. | 250. | |
| 18 Printing & Duplicating | 100. | 100. | |
| 19 Advertising & Promotion | | | |
| -Clergy Conference | 600. | 600. | |
| -Bereavement Info. Pamphlet | 300. | 300. | |
| -Miscellaneous | 100. | 100. | |
| | $ 1,000. | $ 1,000. | |
| 25 Telephone | $ 150. | $ 150. | |
| Total Operating & Maintenance | $ 1,750. | $ 1,750. | |
| CAPITAL OUTLAY | $ 0 | $ 0 | |
| Total Account #403 | $ 8,588. | $ 8,588. | |

*DIVISIONAL PROGRAMS*

*-Cancer Support Group-*
*(404)*

*Goal:* *To provide a forum where patients and their families can discuss their problems, feelings and issues that are associated with life threatening illnesses in a supportive setting.*

*Objectives:*

1. *To convene weekly patients with life threatening illnesses and their families so they may experience mutual support.*
2. *To have these meetings facilitated by a professional group counselor and/or a psychiatrist.*
3. *To educate the physicians in the community of the existence of this group so they may refer their patients to its services.*
4. *To education the general public of the existence of this group so that all who are in need may avail themselves of its services.*

HOSPICE OF THE MONTEREY PENINSULA
Proposed Budget 1981-81

Cancer Support Group : :ount #404

| | Department Request | Recommended Executive Request | Recommended Fiscal Mgt. Committee |
|---|---|---|---|
| EMPLOYEE COSTS | | | |
| | $ 0. | $ 0. | |
| Total Employee Costs | $ 0. | $ 0. | |
| OPERATING AND MAINTENANCE | | | |
| 12 Consultations -Professional Facilitator at $75/wk/48 weeks | $ 3,600. | $ 3,600. | |
| 16 Office Expense - Other -Clerical Needs and Refreshments | 40. | 40. | |
| 30 Rent -Meeting room paid in form of donation to church | 100. | 100. | |
| Total Operating & Maintenance | $ 3,740. | $ 3,740. | |
| CAPITAL OUTLAY | | | |
| | $ 0. | $ 0. | |
| Total Accont #404 | $ 3,740. | $ 3,740. | |

*DIVISIONAL PROGRAMS*

*-Resource Information Center-*
*(405)*

*Goal:* *To provide the entire community with a resource and information center which will educate the community to the philosophy and services of Hospice and have available information concerning the support systems for patients with life threatening illnesses and their families.*

*Objectives:*

1. *To supply books, tapes, articles and current information about life threatening illnesses, treatment modalities and self-help philosophy.*
2. *To provide and coordinate trained speakers to inform the community, groups and agencies about the needs of patients facing life threatening illnesses and about Hospice in general.*
3. *To provide a monthly forum for the public on hospice philosophy.*
4. *To provide workshops and conferences for the public and professionals on specific topics related to oncological care and hospice care.*

HOSPICE OF THE MONTEREY PENINSULA
Proposed Budget 1981-82

Resource Information Center Account #405

| | Department Request | Recommended Executive Request | Recommended Fiscal Mgt. Committee |
|---|---|---|---|
| EMPLOYEE COSTS | | | |
| | $ 0. | $ 0. | |
| Total Employee Costs | $ 0. | $ 0. | |
| OPERATING AND MAINTENANCE | | | |
| 15 Office Expense - Postage | $ 30. | $ 30. | |
| 16 Office Expense Other | | | |
| -Card Index File | 25. | 25. | |
| -Index Cards | 6. | 6. | |
| -Manila Folders | 15. | 15. | |
| -Staplers | 10. | 10. | |
| -Miscellaneous Items | 50. | 50. | |
| | $ 106. | 106. | |
| 17 Books and Periodicals | | | |
| -Books | 500. | 500. | |
| -Magazine Subscriptions | 200. | 200. | |
| -Films | 1,000. | 1,000. | |
| | $ 1,700. | $ 1,700. | |
| 25 Telephone | $ 180. | $ 180. | |
| 30 Rent | $ 2,400. | $ 2,400. | |
| Total Operating & Maintenance | $ 4,416. | $ 4,416. | |
| CAPITAL OUTLAY | | | |
| 53 Furniture & Equipment | | | |
| -Typewriter, IBM Selectric | $ 705. | $ 705. | |
| -File Cabinet w/lock | 195. | 195. | |
| Total Capital Outlay | $ 900. | $ 900. | |
| Total Account #405 | $ 5,316. | $ 5,316. | |

*DIVISIONAL PROGRAMS*

*-Inpatient Facility-*
*(410)*

*Goal:* *To provide inpatient care for patients faced with life threatening illnesses in order to design the home care required for patient comfort, respite care when the family requires it and acute care when necessary.*

*Objectives:*

1. *To open the inpatient facility by July 1, 1981, which requires:*
   a. *Filing for licensing.*
   b. *Minor modifications in the physical facility.*
   c. *Negotiating reimbursement schedules with third-party providers.*
   d. *Screening for staff.*
   e. *Hiring of staff.*
   f. *Training of staff.*
   g. *Building a financial reserve of four months operating costs to provide for the gap time between petition for reimbursement and actual reimbursement.*
2. *To integrate the operation of the inpatient facility with that of the home care operation.*
3. *To develop procedures with hospital discharge coordinators in order to insure easy transition.*

HOSPICE OF THE MONTEREY PENINSULA
Proposed Budget 1981-82

Inpatient Facility (Active July-Dec.) Account #410

| | Department Request | Recommended Executive Request | Recommended Fiscal Mgt. Committee |
|---|---|---|---|
| EMPLOYEE COSTS | | | |
| Salaries | | | |
| 01 Permanent Employees | | | |
| -Medical Director | $ 50,000. | $ 50,000. | |
| -Facility Coordinator | 21,000. | 21,000. | |
| -Hospice Nurse (3) | 51,000. | 51,000. | |
| -Hospice Caregiver (3) | 27,000. | 27,000. | |
| -Dietician/Cook | 9,600. | 9,600. | |
| -Grounds Supervisor | 6,400. | 6,400. | |
| -Custodian | 6,400. | 6,400. | |
| | $171,400. | $171,400. | |
| 02 Part Time Employees | | | |
| -Hospice Nurse (3/3280 hr) | 26,240. | 26,240. | |
| -Hospice Caregiver (3/3280 hr) | 14,170. | 14,170. | |
| -Cook (1100 hrs) | 5,060. | 5,060. | |
| | $ 45,470. | $ 45,470. | |
| Total Salaries | $216,870. | $216,870. | |
| Fringe Benefits | | | |
| 04 Pension Plan (5% gross payroll | $ 11,804. | $ 11,804. | |
| 05 Social Sec.(6.65% in lieu of) | 15,700. | 15,700. | |
| 06 State Unemployment Ins. (3.5%/$6000) | 3,829. | 3,829. | |
| 07 Worker's Compensation Ins.(9%) | 19,518. | 19,518. | |
| 08 Health Ins. (Est.12 at 80/mo.) | 10,560. | 10,560. | |
| Total Fringe Benefits | $ 61,411. | $ 61,411. | |
| Total Employee Costs | $278,281. | $278.281. | |

HOSPICE OF THE MONTEREY PENINSULA
Proposed Budget 1981-82

Inpatient Facility (Active July-Dec) Account #410

| | Department Request | Recommended Executive Request | Fiscal Mgt Committee |
|---|---|---|---|
| OPERATING AND MAINTENANCE | | | |
| 10 Training | $ 750. | $ 750. | |
| 11 Travel (4000 miles at $.20) | 800. | 800. | |
| 12 Consultations | | | |
| -Activities Consultant | 1,200. | 1,200. | |
| 15 Office Expense - Postage | 200. | 200. | |
| 16 Office Expense - Other | | | |
| -Expendable Office Supplies, Maintenance of Equipment | 200. | 200. | |
| 17 Books and Periodicals | | | |
| -Newspaper, Magazines, Patient use, Nursing Publications | 300. | 300. | |
| 18 Duplication & Printing | | | |
| -Miscellaneous Forms | 400. | 400. | |
| -Name Pins & Identification | 50. | 50. | |
| -Copier Usage | 100. | 100. | |
| | $ 550. | $ 550. | |
| 20 Household - Food Supplies | 9,000. | 9,000. | |
| 21 Household - Other Supplies | 700. | 700. | |
| 22 Pool Supply & Maintenance | 600. | 600. | |
| 23 Medical Supplies | | | |
| -Oxygen, Medications, etc. | 1,500. | 1,500. | |
| 24 Grounds - Supply & Maintenance | 600. | 600. | |
| 25 Telephone | | | |
| -Monthly Service | 1,200. | 1,200. | |
| -Pager for Coordinator | 300. | 300. | |
| | $ 1,500. | $ 1,500. | |

HOSPICE OF THE MONTEREY PENINSULA
Proposed Budget 1981-81

Inpatient Facility (Active July-Dec) Account #410

| | Department Request | Recommended Executive Request | Recommended Fiscal Mgt. Committee |
|---|---|---|---|
| OPERATING AND MAINTENANCE | | | |
| 26 Utilities | | | |
| -P.G.E.(50%) | $ 1,200. | $ 1,200. | |
| -Disposal (50%) | 200. | 200. | |
| -Cal Am Water (50%) | 40. | 40. | |
| -Bottled Water | 280. | 280. | |
| -TV Cable | 300. | 300. | |
| | $ 2,020. | $ 2,020. | |
| 27 Fees and Licenses | 100. | 100. | |
| 30 Mortgage Payments | | | |
| -Monterey Savings & Loan | 25,440. | 25,440. | |
| -Zobel Investment | 1,860. | 1,860. | |
| -Ruben et al | 4,100. | 4,100. | |
| | $ 31,400 | $ 31,400. | |
| 33 Insurance | | | |
| -Building Contnts (25%) | 680. | 680. | |
| -Professional Liability & Umbrella | 1,200. | 1,200. | |
| | $ 1,880. | $ 1,880. | |
| Total Operating & Maintenance | $ 53,300. | $ 53,300. | |
| CAPITAL OUTLAY | | | |
| 51 Building | $ 0. | $ 0. | |
| -Patient Call System | 6,000. | 6,000. | |
| -Electrical/Plumbing Repairs | 2,000. | 2,000. | |
| | $ 8,000. | $ 8,000. | |

HOSPICE OF THE MONTEREY PENINSULA
proposed Budget 1981-81

Inpatient Facility (Active July-Dec) Account #410

| | Department Request | Recommended Executive Request | Recommended Fiscal Mgt. Committee |
|---|---|---|---|
| 52 Improvements | | | |
| -Grounds | $ 10,000. | $ 10,000. | |
| 53 Furniture and Equipment | | | |
| -Nursing Station-Desk | 300. | 300. | |
| -Nursing Station-Typewriter | 705. | 705. | |
| -Nursing Station-File Cabinet | 195. | 195. | |
| -Industrial Vacuum Cleanerr | 300. | 300. | |
| | $ 1,500. | $ 1,500. | |
| Total Capital Outlay | $ 19,500. | $ 19,500. | |
| Total Account #410 | $351,081. | $351,081. | |

## *DIVISIONAL PROGRAMS*

### *Home Care*
### *(420)*

*Goal:* *To increase significantly the number of patients who are able to die in their own homes.*

*Objectives:*

1. *To provide nursing evaluation of the patient's medical, psychological and emotional needs.*
2. *To provide twenty-four hour, seven-day-a-week availability.*
3. *To provide pain and symptom control expertise to patients and their families.*
4. *To reduce medical costs inherent in hospitalization.*
5. *To assist patients and their families in obtaining needed social services and in utilizing all relevant community resources.*
6. *To provide family instruction on the care of the patient and encourage family involvement in patient care when appropriate.*

HOSPICE OF THE MONTEREY PENINSULA
proposed Budget 1981-82

Home Care Account #420

| | Department Request | Recommended Executive Request | Recommended Fiscal Mgt. Committee |
|---|---|---|---|
| EMPLOYEE COSTS | | | |
| Salaries: | | | |
| 01 Permanent Employees | | | |
| -Nursing Director | $21,000. | $21,000. | |
| -Registered Nurse (2) | 34,000. | 34,000. | |
| | $55,000. | $55,000. | |
| 02 Part Time Employees | | | |
| -Home Health Aide | 4,500. | 4,500. | |
| 03 Overtime/Standby Time | 720. | 720. | |
| Total Salaries | $60,220. | $60,220. | |
| Fringe Benefits: | | | |
| 04 Pension Plan (5% gross payroll) | 3,011. | 3,011. | |
| 05 Social Sec. (6.65% in lieu of) | 4,000. | 4,000. | |
| 06 State Unemployment Ins. (3.5%/$6000) | 813. | 813. | |
| 07 Worker's Compensation Ins. (6.35%) | 3,824. | 3,824. | |
| 08 Health Ins. ($80/mo) | 2,880. | 2,880. | |
| Total Fringe Benefits | $14,528. | $14,528. | |
| Total Employee Costs | $74,748. | $74,748. | |

HOSPICE OF THE MONTEREY PENINSULA
Proposed Budget 1981-82

Home Care Account #420

| | Department Request | Recommended Executive Request | Fiscal Mgt. Committee |
|---|---|---|---|
| OPERATING AND MAINTENANCE | | | |
| 10 Training | $ 875. | $ 875 | |
| 11 Travel (21,000 miles at $.20) | 4,200. | 4,200. | |
| 12 Consultations | 600. | 600. | |
| 17 Books and Periodicals | 100. | 100. | |
| 18 Duplicating & Printing -Forms | 300. | 300. | |
| 19 Advertising & Promotion | 200. | 200. | |
| 23 Medical Supplies -Reimbursible by Patient | 3,000. | 3,000. | |
| 25 Telephone | | | |
| -Monthly Service (50%) | 2,000. | 2,000. | |
| -Pager (2) | 600. | 600. | |
| | 2,600. | 2,600. | |
| 26 Utilities | | | |
| -P.G.E (25%) | 600. | 600. | |
| -Disposal (25%) | 100. | 100. | |
| -Cal Am Water (25%) | 20. | 20. | |
| -Bottled Water (50%) | 140. | 140. | |
| | $ 860. | $ 860. | |
| 27 Fees and Licenses -CAHSAH Membership | $ 500. | $ 500. | |
| 33 Insurance | | | |
| -Building & Contents (25%) | $ 340. | $ 340. | |
| -Umbrella (50%) | 450. | 450. | |
| -Professional Liability (50%) | 313. | 313. | |
| | $ 1,103. | $ 1,103. | |
| 39 Miscellaneous | $ 100. | $ 100. | |
| Total Operating & Maintenance | $14,438. | $14,438. | |
| CAPITAL OUTLAY | $ 0. | $ 0. | |
| Total Account #420 | $89,186. | $89,186. | |

## *PROGRAM PRIORITIES*

*In setting forth the Program Report for the fiscal year 1981-82, priorities must be set in the event that adequate funds are not available to implement the entire program. It is hoped that the Financial Development program will enable us to meet any deficit, but in the event that it does not we must establish priorities to determine how best to distribute the available funds so that we can achieve the comprehensive goal "To expand without deficit spending the number and quality of services of a specialized program which provides medical, social, psychological and spiritual care to patients faced with life threatening illnesses and their families."*

*Much of the fiscal prioritizing should take place on a line item basis, because we want to retain as much of the total program as we possibly can. Instead of pitting one program against another, economizing can take place in each program to insure the cost effective operation of each program and the retention of as many programs as possible. However, it is still incumbent upon us to prioritize the programs so that we have clearly in mind where we want to allocate the available dollar in the event of scarcity. In doing this we are not judging one program to be more important than another, nor doing better work than another, we are simply making a conscious decision that in the event of a scarcity of funds we know what program has precedence over another in the allocation of available funds.*

*Keeping in mind that line item prioritizing is to take place in each program, I would like to suggest the following priority of programs for the fiscal year 1981-82, with a short rationalization for each.*

1. *Home Care, because*

   *-it is already operative;*

   *-it is already licensed;*

   *-it is the essence of hospice care;*

   *-it is where our services are best exposed to the public for purposes of developing other programs;*

2. *Volunteers, because*

   *-it is already operative;*

   *-it is the essence of hospice care;*

   *-it is also where our services are best exposed to the public for purposes of developing other programs.*

3. *Inpatient facility, because*

   -*there is genuine need in the community for such a facility;*

   -*it can be integrated well into the programs of hospital discharge coordinators;*

   -*it can function as a natural transition into the home care program;*

   -*there is substantial investment already made in this facility.*

4. *Development, because*

   -*substantial giving from the community and foundations is essential for the continuance of any hospice program;*

   -*even assuming maximum reimbursements, substantial deficits will exist without donations and grants.*

5. *Resource Information Center, because*

   -*it is necessary for community education;*

   -*it is a proven support system for those facing life threatening illnesses;*

   -*it can be operative with a substantial volunteer staff.*

6. *Special Services, because*

   -*it is a genuine part of the concept of Hospice;*

   -*it has not been highly developed in our Hospice program;*

   -*most of the goals of this program can be achieved by well trained and highly motivated volunteers.*

7. *Administration, because*

   -*it is necessary for fiscal management and organizational coordination;*

   -*it should, however, be as minimal as possible in order to achieve the main goals of Hospice.*

*8. Cancer Support Group, because*

*-it is a proven support system for those facing life threatening illnesses;*

*-it allows for easy entrance of a patient and his or her family into the total Hospice program if that becomes necessary.*

*Attempts will be made to scrutinize each program budget in order to keep as much of the comprehensive program operative as possible, but if all are agreed to this set of priorities it becomes easier if and when cut-backs must be made in the programs themselves because of restricted finances.*

*RGD:js*

# APPENDIX H

## DEVELOPMENT OF COSTS FOR SERVICES
## KAISER-PERMANENTE-NORWALK

# APPENDIX H

## DEVELOPMENT OF COSTS FOR SERVICES KAISER-PERMANENTE-NORWALK

When possible, existing data on the costs of services were used. However, in certain cases, the costs had to be derived. Below is a description of the procedures employed to determine the cost of each service included in the study.

Inpatient Per Diem Costs:

- Nursing costs per day - these figures represent average nursing payroll and employee benefits costs per day. Medical/surgical and hospice nursing costs per day were developed by multiplying a standard hours per patient day times the average hourly pay rate plus benefits. ICU nursing costs were similarly constructed from 1979 actual hours per patient day for Sunset ICU. Standard hours per patient day were developed in 1980 by Management Engineering for "hospice type" patients at the Los Angeles Medical Center (7.9 hours) and hospice patients (10.8). Since these hours represent worked hours only, an adjustment was made to include total paid hours. Average payrates for Los Angeles routine care and ICU units and for the hospice inpatient unit were obtained from the 1979 Composite Hourly Rates by Job Classification report and are weighted for staff mix. Employee benefits rate was obtained from Financial Planning.

- Other inpatient per diem costs - these figures represent all non-payroll "room and board" costs, including depreciation for building, fixtures, and equipment, general and administrative, maintenance and repairs, plant operation, laundry and linen, housekeeping, dietary, nursing administration, central supply, medical records and interns and residents. The medical/surgical other per diem costs were calculated by subtracting the routine care nursing payroll and benefits cost (actual routine care hours times pay and benefits) from the routine care cost for Sunset Facility. The source for the routine care was the Summary of unit Costs for Part A Services for Year Ended December 31, 1979, Sunset Facility. The same other per diem cost figures were used for hospice since no medical or care pattern difference affecting the above costs was identified.

- Other ICU per diem costs were calculated in the same manner using the difference between ICU nursing payroll and benefits costs and the ICU cost per day for the Los Angeles facility.

- Medications per diem costs - these include medications given to the patient while in an inpatient unit. Hospice costs were obtained from inpatient pharmacy costs collected between March 1, 1980 and September 30, 1980 for the NCI Hospice Cost Study. The cost was deflated 12% to estimate 1979 costs. Total medical/surgical and ICU costs were obtained from the Summary of Unit Costs for Part A Services, Sunset Facility and divided by total inpatient days. The same cost was used for both types of care since the source does not differentiate between type of service.

APPENDIX H (Contd)

- Physician inpatient costs - these include direct payroll and benefit costs for visits by physicians to inpatients. Average visit time for hospice physicians was obtained from the NCI Hospice Cost Study. No data on medical/surgical or ICU visit times were identified thus the study team estimated physician visit time to be somewhat less than at hospice due to differences in location and care patterns. Visit times were multiplied by average salary information for physicians. No indirect time was calculated.

- Social Worker inpatient costs - these include direct payroll and benefits costs for social medicine services to inpatients. Hospice costs were developed from time data collected for the NCI Hospice Cost Study and 1979 average pay for social workers. Medical/surgical and ICU costs were calculated using 1979 Sunset payroll and benefits costs for social workers times the Sunset 1979 Medicare inpatient to total social medicine cost ratio divided by total Sunset days. Social worker costs were obtained from SCPMG - regional offices. The Medicare inpatient ratio was obtained from the Calculation of Reimbursable Cost of Home Health Services 1979, report and Sunset days were obtained from the 1979 Hospital Activity Report.

- Skilled Nursing Facility Inpatient Day - the source was the Summary of Payments for Supplemental Hospitalization, SNF, January to August, 1979. The average outside SNF charge for Sunset facility patients was used.

Anesthesiology: The source was the Summary of Unit Cost for Part A Services for Year Ended December 31, 1979, Sunset Facility.

Surgery: The source was the Summary of Unit Cost for Part A Services for Year Ended December 31, 1979, Sunset Facility. Additional direct physician time costs were added assuming one physician during entire surgery time.

Laboratory - Inpatient Medicare, Inpatient Non-Medicare and Outpatient: The source was the Summary of Unit Cost for Part A Services for Year Ended December 31, 1979, Sunset Facility. Cost per requisition was calculated by multiplying the cost per RVU's per requisition.

Outpatient Chemotherapy Treatment: To develop this cost, the average cost of outpatient chemotherapy medications ($22.58) was added to the basic cost of a physician outpatient visit. The medication cost was obtained by dividing the total cost of outpatient chemotherapy medications for 1979 (obtained from the Regional Pharmacy Department), by the total number of chemotherapy visits in 1979 (obtained from the Financial Management System). The development of the cost of the physician outpatient visit is explained in another section of this appendix.

Radiation Therapy Treatment - (4MV): These costs were obtained from the July 1, 1977 Fee Schedule (procedure number 77031). These charges were the same in 1979.

APPENDIX H (Cont'd)

Physician Outpatient Visits: The source was the Group Practice Prepayment Plan, Statement of Reimbursement Cost, 1979.

Radiology - Inpatient Medicare, Inpatient Non-Medicare, Outpatient: The source was the Summary of Unit Costs for Part A Services for Year Ended December 31, 1979, Sunset Facility. Cost per requisition was calculated by multiplying the cost per RVU on the schedule by the average RVU's per requisition.

EEG: The source was the Summary of Unit Costs for Part A Services for Year Ended December 31, 1979, Sunset Facility.

EKG: The source was the Summary of Unit Costs for Part A Services for Year Ended December 31, 1979, Sunset Facility.

Nuclear Medicine Procedure: The source was the Summary of Unit Costs for Part A Services for Year Ended December 31, 1979, Sunset Facility.

Physician Consults: This figure was obtained from the August 1, 1979 Fee Schedule (Procedure Number 90605).

Emergency Area: The source was the Summary of Unit Costs for Part A Services for Year Ended December 31, 1979, Sunset Facility.

Ambulance Service: The source was data from the NCI Cost Report, Hospice: A Cost Analysis of Three Programs. A three month sample of all ambulance trips (N=99) was used to calculate the average charge per trip.

Home Care Visits - Physician: This figure was obtained from the August 1, 1979 Fee Schedule (Procedure Number 90150).

Home Care Visits - Registered Nurse, Home Health Aide, Social Worker: The source was the Calculation of Reimbursable Cost of Home Services, 1979.

Home Care Visits: Licensed Vocational Nurse. The source was data from the NCI Cost Report, Hospice: A Cost Analysis of Three Programs. The figure was based on the home care licensed vocational nurse payroll and employee benefits costs divided by the licensed vocational nurse home care visits plus 40% overhead.

Physical Therapy Visit: The source was the Calculation of Reimbursable Cost of Home Health Services, 1979.

# APPENDIX I

## KAISER-PERMANENTE-NORWALK
## AVERAGE UTILIZATION OF SERVICE RATES

APPENDIX I

KAISER-PERMANENTE-NORWALK
AVERAGE UTILIZATION OF SERVICE RATES

| Service | Hospice | Non-Hospice |
|---|---|---|
| | Average N = 32 | Average N = 27 |
| Hospice nursing per day | 10.34 | 0 |
| Hospice physician per day | 10.34 | 0 |
| Hospice social worker per day | 10.34 | 0 |
| Hospice medications per day | 10.34 | 0 |
| Hospice other per diem | 10.34 | 0 |
| Medical/surgical nursing per day | 0 | 14.25 |
| Medical/surgical physician per day | 0 | 14.25 |
| Medical/surgical social worker per day | 0 | 14.25 |
| Medical/surgical medications per day | 0 | 14.25 |
| Medical/surgical other per diem | 0 | 14.25 |
| ICU nursing per day | 0 | .04 |
| ICU physician per day | 0 | .04 |
| ICU medications per day | 0 | .04 |
| ICU other per diem | 0 | .04 |
| SNF day | 0 | 2.33 |
| Anesthesiology hours | 0 | .55 |
| Surgery hours | 0 | .40 |
| Inpatient laboratory requisitions (Medicare) | - | - |
| Inpatient laboratory requisitions (Non-Medicare) | .50 | 32.96 |
| Inpatient radiology requisitions (Medicare) | - | - |
| Inpatient radiology procedures (Non-Medicare) | .06 | 3.67 |
| EEG procedures | 0 | .19 |
| EKG procedures | 0 | .78 |
| Nuclear procedures | 0 | .19 |
| Radiation therapy | 0 | 0 |
| Physician consults | .06 | .56 |
| Emergency room hours | 0 | 5.34 |
| Ambulance trips | 1.22 | .22 |
| Outpatient laboratory requisitions | .13 | .59 |
| Outpatient radiology requisitions | 0 | .22 |
| Doctor office visits | 0 | 1.48 |
| Chemotherapy treatments | 0 | .11 |
| Physical therapy treatments | 0 | .22 |
| Physician home visits | .78 | .07 |
| RN home visits | 5.63 | .11 |
| HHA home visits | .44 | .11 |
| LVN home visits | .16 | .19 |
| MSW home visits | .13 | .07 |

APPENDIX J

KAISER-PERMANENTE-NORWALK
PERCENTAGE OF COSTS ATTRIBUTABLE TO EACH SERVICE

APPENDIX J

KAISER-PERMANENTE NORWALK
PERCENTAGE OF COSTS ATTRIBUTABLE
TO EACH SERVICE

| SERVICE | PERCENTAGE OF COST | |
|---|---|---|
| | Hospice | Non-Hospice |
| **Inpatient Per Diem** | | |
| Nursing | | |
| Routine | 42% | 30% |
| ICU | 0 | 1 |
| Other Per Diem | | |
| Routine | 35 | 31 |
| ICU | 0 | 1 |
| Physician | 4 | 3 |
| Social Worker | 1 | * |
| Medications | 1 | 6 |
| SNF | 0 | 6 |
| Subtotal: Percentage | 83% | 78% |
| Subtotal: Cost | $2414 | $2742 |
| **Surgery and Anesthesia** | | |
| Surgery | 0 | 1 |
| Anesthesia | 0 | 1 |
| Subtotal: Percentage | 0% | 2% |
| Subtotal: Cost | $ 0 | $ 84 |
| **Ancillary - Outpatient and Inpatient** | | |
| Inpatient Laboratory - Medicare | 0 | 2 |
| Inpatient Laboratory - Non-Medicare | * | 3 |
| Inpatient Radiology - Medicare | 0 | 1 |
| Inpatient Radiology - Non-Medicare | * | 2 |
| Outpatient Laboratory | * | * |
| Outpatient Radiology | 0 | * |
| EEG | 0 | * |
| EKG | 0 | * |
| Nuclear Medicine | 0 | * |
| Radiation Therapy | 0 | * |
| Chemotherapy - Outpatient | 0 | * |
| Physical Therapy | 0 | 1 |
| Subtotal: Percentage | * | 10% |
| Subtotal: Cost | $ 3 | $345 |

APPENDIX J

KAISER-PERMANENTE NORWALK
PERCENTAGE OF COSTS ATTRIBUTABLE
TO EACH SERVICE (Contd)

| SERVICE | PERCENTAGE OF COST | |
|---|---|---|
| | Hospice | Non-Hospice |
| **Home Care** | | |
| Physician | 1 | * |
| RN | 12 | 1 |
| HHA | 1 | * |
| LVN | * | * |
| MSW | * | * |
| Subtotal: Percentage | 14% | 1% |
| Subtotal: Cost | $402 | $ 49 |
| **Other Miscellaneous** | | |
| Physician Consult | * | 1 |
| Emergency Room | 0 | 6 |
| Ambulance | 4 | 1 |
| Doctor Office Visit | 0 | 2 |
| Subtotal: Percentage | 4% | 10% |
| Subtotal: Cost | $110 | $342 |
| TOTAL: PERCENTAGE | 101% | 101% |
| TOTAL: COST | $2929 | $3562 |

*Less than .05 percent of the cost.

# APPENDIX K

## COMPARATIVE COST DATA FOR PATIENTS WHO DIED IN NON-HOSPICE PROGRAM GROUP (APRIL-SEPTEMBER, 1977) VERSUS HOSPICE PROGRAM GROUP (APRIL-SEPTEMBER, 1978)

APPENDIX K

COMPARATIVE COST DATA FOR PATIENTS WHO DIED
IN NON-HOSPICE PROGRAM GROUP (APRIL-SEPTEMBER, 1977)
VERSUS HOSPICE PROGRAM GROUP (APRIL-SEPTEMBER, 1978)

| | Cost Per Patient | | | Cost Per Diem | | |
|---|---|---|---|---|---|---|
| | Non-Hospice | Hospice | % Change | Non-Hospice | Hospice | % Change |
| Inpatient | | | | | | |
| Basic Care | $2424 | $2688 | +11 | $ 146 | $ 173* | +18 |
| Physician | $ 453 | $ 388 | -14 | $ 27 | $ 25 | -7 |
| Laboratory | $1073 | $ 238 | -78 | $ 65 | $ 15 | -77 |
| Radiology | $ 96 | $ 72 | -25 | $ 6 | $ 5 | -17 |
| Nuc Medicine | $ 41 | $ 12 | -71 | $ 2 | $ 1 | -50 |
| Operating Rm | $ 321 | $ 187 | -42 | $ 19 | $ 12 | -37 |
| Other | $ 16 | $ 22 | -- | $ 1 | $ 1 | -- |
| TOTAL | $4424 | $3607 | -18% | $ 266 | $ 232 | -13% |
| Clinic | | | | | | |
| Emerg Room | $ 16 | $ 15 | -6 | | | |
| Physician | $ 76 | $ 70 | -8 | | | |
| Laboratory | $ 93 | $ 70 | -23 | | | |
| Radiology | $ 45 | $ 34 | -24 | | | |
| Nuc Medicine | $ 25 | $ 7 | -72 | | | |
| Home Health | 0 | $ 54 | -- | | | |
| Other | $ 1 | $ 8 | -- | | | |
| TOTAL | $ 256 | $ 260 | +2 | | | |
| Total Inpatient and Clinic | $4680 | $3867 | -17% | | | |

*The Hospice period includes inpatient days in a traditional setting as well as in the Hospice unit. Basic care charges on the Hospice unit itself would be $214 per diem. The $68 increase consists of $31 nursing, $35 Hospice team care and $2 supervisory and clerical.

# APPENDIX L

## ADJUSTED COST DATA EXCLUDING MOST EXPENSIVE PATIENT IN EACH GROUP

# APPENDIX L

## ADJUSTED COST DATA EXCLUDING MOST EXPENSIVE PATIENT IN EACH GROUP

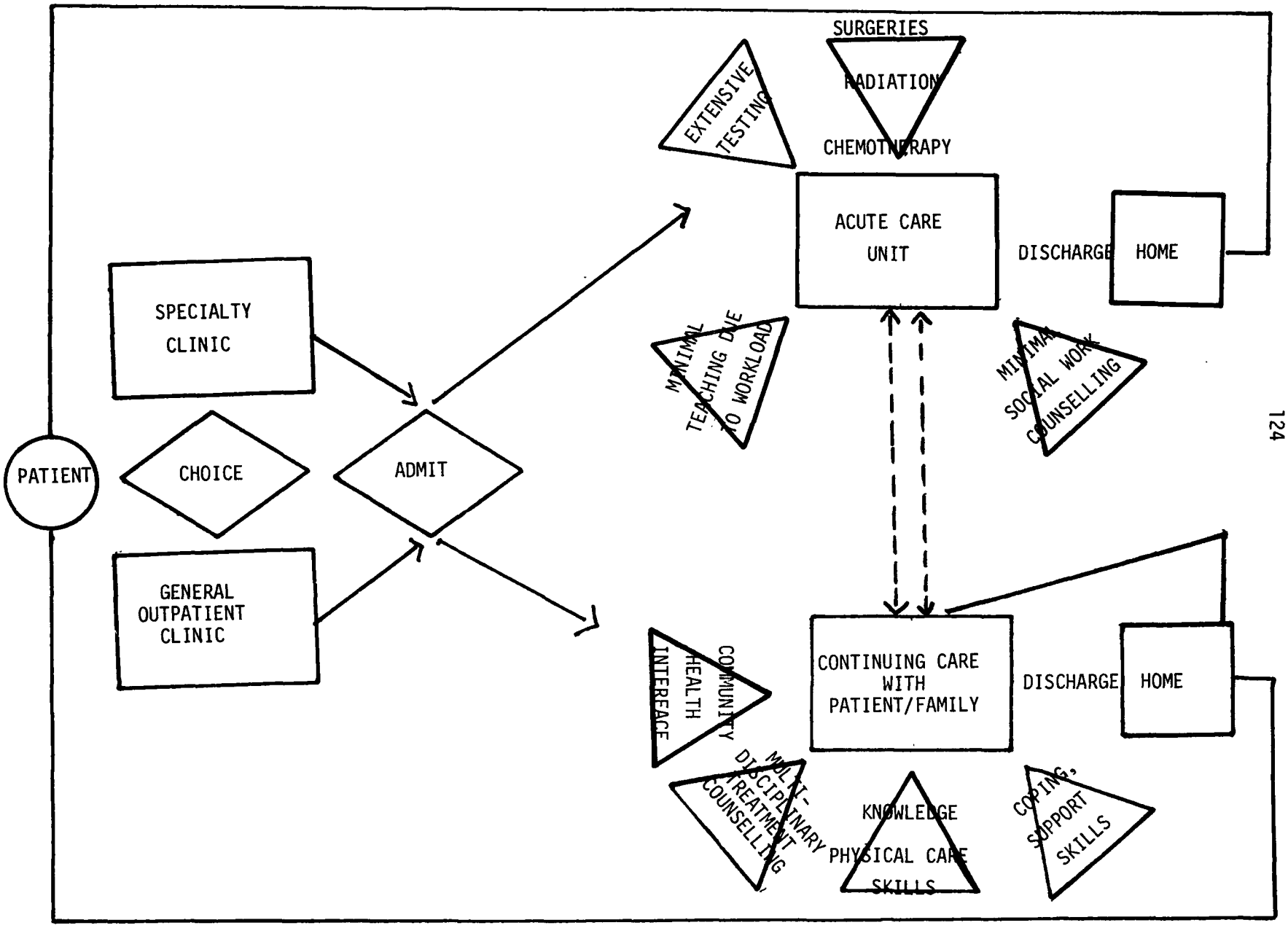
| | Cost Per Patient | | |
|---|---|---|---|
| | Non-Hospice | Hospice | % Change |
| Inpatient | | | |
| Basic Care | $2305 | $2597 | +13 |
| Physician | $ 426 | $ 372 | -13 |
| Laboratory | $ 376 | $ 240 | -36 |
| Radiology | $ 79 | $ 72 | - 9 |
| Nuclear Medicine | $ 37 | $ 13 | -65 |
| Operating Room | $ 271 | $ 179 | -34 |
| Other | $ 16 | $ 23 | -- |
| Total | $3510 | $3496 | -0- |
| Clinic | | | |
| Emergency Room | $ 16 | $ 15 | - 6 |
| Physician | $ 77 | $ 71 | - 8 |
| Laboratory | $ 96 | $ 72 | -25 |
| Radiology | $ 45 | $ 34 | -24 |
| Nuclear Medicine | $ 24 | $ 7 | -71 |
| Home Health | 0 | $ 55 | -- |
| Other | $ 1 | $ 8 | -- |
| Total | $ 259 | $ 262 | 1 |
| Total Inpatient and Clinic | $3769 | $3758 | 0 |

# APPENDIX M

## INTEGRATION OF THE CONTINUING CARE UNIT WITHIN ACUTE CARE SETTING

APPENDIX M

INTEGRATION OF THE CONTINUING CARE UNIT
WITHIN ACUTE CARE SETTING

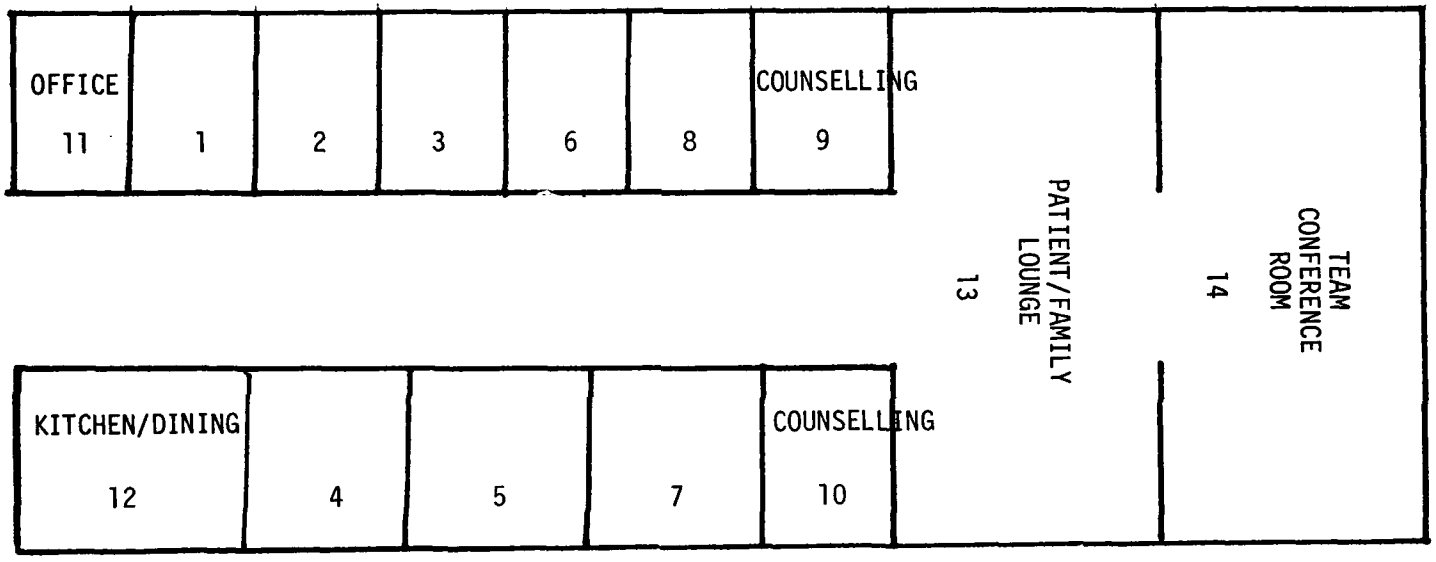


# APPENDIX N

## PROPOSED DESIGN -- CONTINUING CARE UNIT

APPENDIX N

PROPOSED DESIGN -- CONTINUING CARE UNIT




1-8 = 8 Private Rooms for Patient and Family Utilization

9,10 = Counselling Rooms for Interdisciplinary Team Counselling/Teaching

11 = Office for Files/Phone/Charts

12 = Kitchem with Limited Dining

13 = Patient/Family Lounge/Dining

14 = Team Conference Room

# APPENDIX O

## PROACTIVE SCHEDULE X

**MANPOWER SURVEY REPORT -SCHEDULE X - MANPOWER AND WORKLOAD DATA**

For use of this form, see AR 570-4; the proponent agency is the Office of the Assistant Chief of Staff for Force Development.

REPORTS CONTROL SYMBOL CSFOR-76

| MAJOR STAFF ELEMENT | DIVISION | BRANCH | SECTION OR UNIT | SHEET NO. | LINE NO. |
|---|---|---|---|---|---|
| Professional | Dept of Nursing | Clinical Service - Med | Continuing Care Unit | 14 | 7 |

DESCRIPTION OF WORK PERFORMED: This will be a pilot program for the Army. Treatment and education of patients and their families in dealing with chronic, eventually debilitating disease. Individualized training will be given in physical skills for caring for the bedridden patient's special problem, what to expect as far as disease progress and coping skills to allow patient to stay at home.

YARDSTICK CODE: NA
Local Appraisal

WORK UNIT: Daily Average Beds Occupied

**SECTION A - SUMMARY OF MANPOWER**

| Currently Recognized | OFF a | WO b | ENL c | US CIV d | NON-US CIV e | TOTAL MANPOWER SUBJ TO ALLOC f | OTHER MANPOWER US g | OTHER MANPOWER NON-US h | TOTALS i |
|---|---|---|---|---|---|---|---|---|---|
| 1. ALLOCATION | | | | | | 0 | | | 0 |
| 2. ACTUAL STRENGTH | | | | | | | | | 0 |
| 3. RECM BY CO | | | | | | 15 | | | 15 |
| 4. RECM BY SURVEY TEAM | | | | | | | | | |

YARDSTICK ALLOWANCE COMPUTATION

**SECTION B - PERFORMANCE DATA**

| YEAR AND MONTH 19__ a | MANPOWER AVG STR b | MANPOWER TOTAL MAN-HOURS WORKED c | MANPOWER HRS OP IN MO d | MANPOWER EQUIV MAN-MONTHS (c ÷ d) e | WORKLOAD NO. OF WORK UNITS f | WORKLOAD W/L PER PERSON (f ÷ e) g |
|---|---|---|---|---|---|---|
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| | | | | | | |
| 1. WORKLOAD USED AS BASIS OF APPRAISAL | | | | | 8 | |
| 2. AVERAGE PRODUCTIVITY | | | | | | |

3. MANPOWER ALLOWANCE

SURVEY WORKLOAD (1) ( ) / AVG PRODUCTIVITY (2) ( ) = ____ × 1.11 = ____

**SECTION C - MANPOWER**

| ALLOC STR a | RANK OR GRADE b | ACTUAL STR c | RANK OR GRADE d | JOB TITLE e |
|---|---|---|---|---|
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AMS CODE: 847711.12000

TDA PARA: New

DA FORM 1 NOV 73 140-4

PREVIOUS EDITIONS OF THIS FORM ARE OBSOLETE.

SECTION D - SPECIFIC REMARKS

COMMANDER

An eight bed Continuing Care Unit is proposed to treat and educate patients and their families in dealing with chronic, eventually debilitating disease, i.e., COPD, cancer, cirrhosis, etc. Such a unit has no precedence in the Army health care system, so a proactive Schedule X is submitted to establish a pilot study to ascertain cost effectiveness and patient success over a 12 month study. The ramifications will be Army wide.

The Continuing Care Unit will not be an acute care unit, dealing with acute medically oriented admissions. Instead, it will focus on patient and family education, training them in physical skills for caring for the bedridden patient, foley catheter care, etc. Also, they will be taught what to expect as far as disease progress and coping skills so that the patient can stay out of the hospital in his own home for longer periods of time. A telephone consultation service will be available on a 24 hour basis in support of the above mentioned skills.

An 8 bed unit means a normal patient load of 8 and at least 8 corresponding family members. Each family unit (patient plus family member) will be taught as a unit or separately as needed. Group instruction will not be utilized due to variations in age, disease process, education, cultural and social background. The success of such a program will be dependent upon a staff large enough to effectively teach without interruption. The following staff compliment is needed for adequate testing of the pilot.

Nurse $\left.\begin{array}{l} 1 \times 24 \times 7 \div 40 \times 1.11 = 4.66 \\ 1 \times 12 \times 7 \div 40 \times 1.11 = 2.33 \end{array}\right) = 6.99 = 7$

Assistants $\left.\begin{array}{l} 1 \times 24 \times 7 \div 40 \times 1.11 = 4.66 \\ 1 \times 8 \times 7 \div 40 \times 1.11 = 1.62 \end{array}\right) = 6.28 = 6$

Ward Clerk $1 \times 16 \times 5 \div 40 \times 1.11 = 2.22 = 2$

Total staffing required equals 15 positions.

# APPENDIX P

## CONTINUING CARE TEST DATA

APPENDIX P

CONTINUING CARE TEST DATA
(Filled out for each Admission)

NAME:_____

SEX OF PATIENT:_____

BIRTH DATE:_____

MARITAL STATUS: Married Single Widowed Divorced

FAMILY MEMBER(S), SIGNIFICANT OTHER INVOLVED IN CARE:

_____

_____

_____

DISEASE(S):_____

_____

_____

DATES OF TREATMENT IN CONTINUING CARE UNIT:

FROM:_____ TO:_____

FOR ADMISSION, NOTE THE NUMBER OF THE FOLLOWING TREATMENTS EXPERIENCED:

PHYSICIAN:_____

NURSE CLINICAL COORDINATOR:_____

NURSING CONTACT HOURS (by computer, Dept of Nursing):_____

_____

COMMUNITY HEALTH:_____

PHARMACY:_____

LABORATORY PROCEDURES:_____

DIAGNOSTIC XRAY:_____

THERAPEUTIC X-RAY_____

CLERGY:_____

APPENDIX P, CONTINUING CARE TEST DATA (Contd)

SOCIAL WORK:_____

DIETARY:_____

PHYSICAL THERAPY:_____

OCCUPATIONAL THERAPY:_____

RESPIRATORY THERAPY:_____

BLOOD PRODUCTS:_____

WAS EQUIPMENT PROVIDED BY LOGISTICS?_____

WHAT EQUIPMENT WENT HOME WITH PATIENT?_____

_____

SUPPLIES, I.E., DRESSINGS ACCOMPANYING PATIENT HOME (Please List):

_____

_____

_____

# APPENDIX Q

## CONTINUING CARE SURVEY
## (PHYSICIANS, NURSES)

APPENDIX Q

CONTINUING CARE SURVEY
(PHYSICIANS, NURSES)

Check Appropriately:

M.D.

Nurse

Name:_____

Dept or Service:_____

1. Physicians, have you had any experience utilizing the Continuing Care Unit:

(0 Patients) (1-5 Patients) (6-10 Patients) (11 or more)

2. Nurses, have you worked on the Continuing Care Unit?

(no) (A Little) (Often) (A Great Deal)

3. If you have not worked on the Unit, why?

_____a. Never had the opportunity.

_____b. Don't believe in it.

_____c. No need in my specialty.

_____d. Don't understand focus of Unit.

_____e. Other_____

_____

_____

4. Any other comments:_____

_____

_____

_____

_____

_____

APPENDIX Q, CONTINUING CARE SURVEY (PHYSICIANS, NURSES) (Contd)

5. I consider the quality of care on the inpatient unit good.

| Strongly Disagree | | | | | Strongly Agree |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |

6. The Continuing Care Unit has favorably affected the care of patients.

| Strongly Disagree | | | | | Strongly Agree |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |

7. The Continuing Care Unit has favorably affected the care of family members.

| Strongly Disagree | | | | | Strongly Agree |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |

8. The Continuing Care Unit should be continued.

| Strongly Disagree | | | | | Strongly Agree |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |

9. The Continuing Care Program should be available at other Armed Forces facilities.

| Strongly Disagree | | | | | Strongly Agree |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |

10. My contacts with this unit have changed my approach to the care of the chronically debilitated.

| Strongly Disagree | | | | | Strongly Agree |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |

11. I would recommend the Continuing Care Program to friends and family if appropriate.

| Strongly Disagree | | | | | Strongly Agree |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |

# APPENDIX R

## CONTINUING CARE SURVEY
## (ADMINISTRATORS, DEPARTMENT CHIEFS, HEAD NURSES)

APPENDIX R

CONTINUING CARE SURVEY
(ADMINISTRATORS, DEPARTMENT CHIEFS, HEAD NURSES)

NAME:_____

DEPARTMENT:_____

1. My overall perceptions of the Continuing Care Program are favorable.

| Strongly Disagree | | | | | Strongly Agree |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |

2. My staff has reacted favorably to the Continuing Care Unit.

| Strongly Disagree | | | | | Strongly Agree |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |

3. I have had many contacts with the Unit.

| Strongly Disagree | | | | | Strongly Agree |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |

4. I received sufficient information to integrate my department's services with the Continuing Care Unit.

| Strongly Disagree | | | | | Strongly Agree |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |

5. The quality of care of our chronically debilitated patients has improved since inception of this program.

| Strongly Disagree | | | | | Strongly Agree |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |

6. My department's problems with the unit have been resolved.

| Strongly Disagree | | | | | Strongly Agree |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |

APPENDIX R, CONTINUING CARE SURVEY (ADMINISTRATORS, DEPARTMENT CHIEFS, HEAD NURSES) (Contd)

7. I would enjoy seeing the Continuing Care Unit remain active as an inpatient unit.

| Strongly Disagree | | | | | Strongly Agree |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |

8. My suggestions for continuing the Unit are as follows:

# APPENDIX S

## CONTINUING CARE SURVEY
## PATIENTS/FAMILY

APPENDIX S

CONTINUING CARE SURVEY
PATIENTS/FAMILY

1. NAME:_____

2. DATES OF ADMISSION:_____

3. PHYSICIAN:_____

4. DIAGNOSIS:_____

_____

5. Have you been admitted to the Continuing Care Unit before this admission?

(Circle One) Yes No

6. I consider the quality of care on this Unit to be good.

| Strongly Disagree | | | | | Strongly Agree |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |

7. The Continuing Care Unit should be continued.

| Strongly Disagree | | | | | Strongly Agree |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |

8. The Continuing Care Unit should be continued in other Armed Forces Hospitals.

| Strongly Disagree | | | | | Strongly Agree |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |

9. My contacts with the interdisciplinary team (nurses, doctors, social workers, Occupational Therapy, Physician Therapy, dietitians, pharmacists, etc.) have positively affected my approach to my disease.

| Strongly Disagree | | | | | Strongly Agree |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |

APPENDIX S, CONTINUING CARE SURVEY (PATIENTS/FAMILY) (Contd)

10. I would recommend the Continuing Care Program to friends and family if appropriate.

| Strongly Disagree | | | | | Strongly Agree |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |

11. Other Comments:

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